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2019 Benefits Overview

BUTTE SCHOOLS
SELF-FUNDED PROGRAMS

4/1/2019

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The BSSP logo indicates important or new information to note in this Overview.

Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see Annual Legal Notices for more details.

Your Benefits. Your Choice.

At Butte Schools Self-Funded Programs, we believe that you are our most important asset. Helping you and your family achieve and maintain good health—physical, emotional and financial—is the reason Butte Schools Self-Funded Programs offers you this benefits program. We are providing you with this overview to help you understand the benefits available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

The medical benefits displayed are only available to eligible active employees and retirees not yet age 65 or qualified for Medicare. If you are a retiree age 65 or older, or qualified for Medicare, please contact your district's Human Resources/Benefits office for information regarding your benefit options.

The benefits in this summary are effective:

October 1, 2019 – September 30, 2020

Open Enrollment Closes June 27, 2019 at 3PM

Changes effective October 1, 2019

	For more information within this booklet, see …
Medical Anthem plan rate increases vary by plan and average 7.2% after a $4 rate credit by BSSP. There are no benefit changes.	*Medical and Prescription Plans*
Dental Each dental plan rate reflects a 5% rate reduction. There are no benefit changes.	*Dental*
Vision Vision rates remain the same. The copay for standard progressive lenses is now $0 on all plans.	*Vision*

Other Important Information & Reminders

	For more information within this booklet, see …
Consider enrolling children under each parent for double coverage. In rare instances of high medical claims, benefit reserve provisions may allow the secondary coverage to reduce out of pocket medical costs.	*Do You Have Double Coverage?*
To ensure you are maximizing your benefits and minimizing your out of pocket costs, review the Anthem Blue Cross benefit restrictions and limitations, such as the Value Based Site of Care provision.	*Benefit Restrictions and Limitations*
BSSP offers even more benefits to help you get and stay healthy. Take a few minutes to review the value-added benefits available with your BSSP coverage.	*Health & Wellness Centers* *Free Counseling Services - Anthem EAP* *Expert Medical Opinions - Advance Medical* *Virtual Office Visits - MDLIVE* *Free Generic Medications - Costco* *No or Low Cost Surgery Benefit - Carrum Health* *Diabetes Prevention - Solera4ME*

Open Enrollment

Butte Schools Self-funded Programs will hold its annual Open Enrollment from mid-April through 3:00 p.m. on June 27, 2019, to provide all eligible members with an opportunity to change to their benefit elections. Changes include:

- Electing a different medical, dental and/or vision plan
- Adding or deleting dependents from your coverage

All changes will be effective October 1, 2019 through September 30, 2020.

During Open Enrollment, you may add qualified dependents to your coverage. To do so, you will need to:

1. Complete the Membership Change Form available at www.bsspjpa.org or through your secure benefits portal at www.vbas.com.
2. Submit required dependent documentation, along with the Membership Change Form, to your employer's Human Resources/Benefits office by June 27th at 3:00pm. *See page 2 of Membership Change form for a list of acceptable documents.*

This opportunity applies to those members who will continue to be an active employee after September 30, 2019, who have previously retired, or who are on COBRA. If you plan to retire by September 30, 2019, contact your district's Human Resources/Benefits office for information about your eligibility for and the cost of post-employment medical, dental and vision benefits through BSSP.

If you wish to continue coverage with the same elected plans and dependents in 2019, you do not need to visit the open enrollment portal.

Open Enrollment continued…

CHANGING YOUR BENEFITS THROUGH VBAS

To make changes to your benefits, visit the online enrollment website at www.bsspjpa.org.

If you do not wish to make any changes to your coverage, you do not need to login to Vbas!

1. Visit www.Vbas.com and you'll be directed to the Butte Schools Self-Funded Programs' home page on the Vbas system. Enter the following information, in order:
    a. Your **User Name:** BSSP; last 4 digits of your Social Security Number; your 4-digit birth year; first initial of your first name and first initial of your last name
        Example: "BSSP55551900CP"
    b. Your **Password:** Benefit; last 4 digits of your Social Security number; and the 4-digit year of your birth
        Example: "Benefit55551900"

If you have problems logging into Vbas, contact BSSP at bssp@bsspjpa.org.

2. Click **Sign-In.**

3. From this page, you now have 24/7/365 quick access to your secure accounts at Delta Dental and VSP, as well as quick links to Anthem, other benefit information and portals through BSSP. To continue with your Open Enrollment elections, click on the **Vbas** button.
4. If prompted for the **Vbas User Agreement**, click **Accept**.
5. Create your **New Password.** Because your initial password is only temporary, you must create your own personal password. Choose a minimum of 8 characters (a combination of numbers as well as upper and lower case letters). Re-enter your new password to confirm.
6. Click **Save** to store your new password.
7. Before you begin your enrollment, you will be asked to verify your personal information. To begin the verification process, click **Get Started**.
    a. Review your information displayed. To change any information on this page, please contact your employer's Human Resources/Benefits office.
    b. Add or delete any dependents in Vbas, and
        i. Complete the Membership Change Form available at www.vbas.com or www.bsspjpa.org.
        ii. Submit required dependent documentation, along with the Membership Change Form, to your employer's Human Resources/Benefits office by June 27th at 3:00pm. *See page 2 of Membership Change form for a list of acceptable documents.*
8. When you have finished the verification process look for **Verification Completed** on the right side of the screen.

Open Enrollment continued…

CHANGING YOUR BENEFITS THROUGH VBAS continued…

9. Click **Make your Open Enrollment Elections** to begin selecting your benefits effective October 1, 2019.

   IMPORTANT: Employer rates are reflected for full-time employees, only, and may be subject to collectively bargained changes. Ask your Human Resources/Benefits office for more information.

In VBAS, plan options may display in a different order than in other materials. Be sure to read plan titles carefully to ensure you are selecting your intended plan.

10. Click **Next** to move from page to page, selecting your benefits and covered dependents. If you make any changes, click **Save** afterward.
11. Once you are satisfied with your choices, click **Submit Elections** to complete your enrollment and print your Open Enrollment Election Summary. You can also click on the **Printable Summary** button.
12. Click **Sign Out** when you are finished. That's it! You've enrolled!

Maximizing Your Benefits

Be ready to access your benefits when you need them. Each benefit partner offers robust online and mobile tools by which you can access your benefit information. Through most, you can access information regarding network providers, the status of pending claims, year-to-date deductible and out of pocket amounts and much more.

BOOKMARK THE BSSP WEBPAGE: www.bsspjpa.org

At our website, you will find helpful information including plan summaries, information about the Health and Wellness Center and much more.

SCHEDULE A HEALTH RISK ASSESSMENT (HRA)

Annually you must complete a Health Risk Assessment (HRA) to be eligible to utilize services at the HWCs, so call 530-879-7582 or 530-532-5918 to schedule yours today. HRAs are available at no cost to any covered member and will also qualify you for a $20 incentive. The HRA is a biometric health screening including the following:

- Health and Wellness Questionnaire
- A fasting blood test for triglycerides, cholesterol, blood sugar and prostate antigen
- Measurement of blood pressure, height and weight
- Evaluation of body mass index

CREATE PATIENT PORTALS

Create an online account/patient portal for the carriers listed below. These portals will give you access to year-to-date out of pocket amounts, search for network providers and confirm your eligibility for benefits. Click the link for each to set up your account.

- Anthem (medical): www.anthem.com/ca/sisc
- Navitus (prescription): https://members.navitus.com/
- Kaiser (if applicable): www.kp.org
- MDLIVE (virtual office visit): www.mdlive.com/sisc
- Delta Dental (dental): www.deltadental.com
- VSP (vision): www.vsp.com

VISIT VBAS FOR EASY ACCESS TO MANY BENEFIT PORTALS

During open enrollment, you accessed the Vbas benefits portal at www.Vbas.com. Return to Vbas for quick access to many of the benefit partners through BSSP.

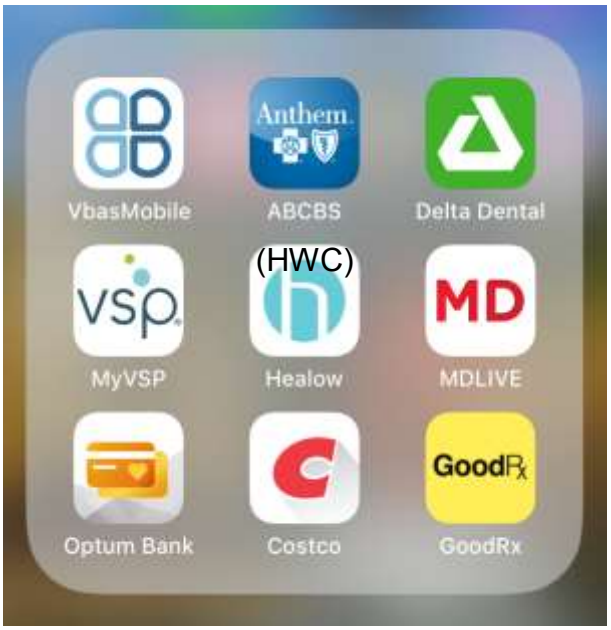
Maximizing Your Benefits continued…

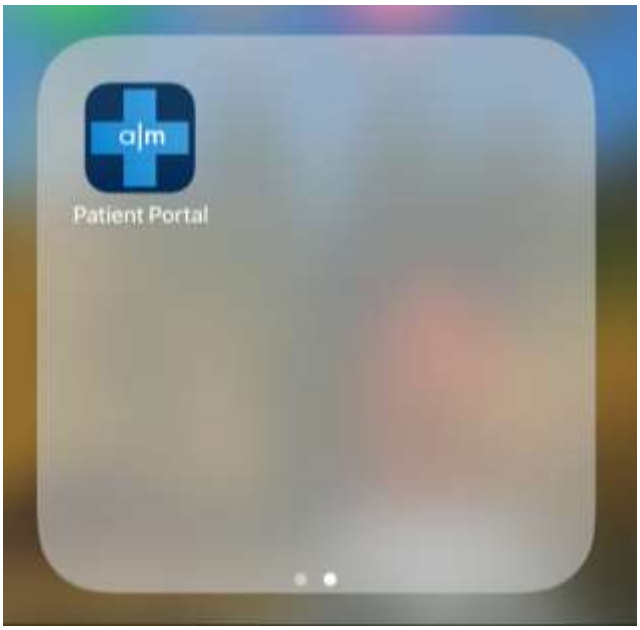
INSTALL APPS ON YOUR MOBILE DEVICE

Many benefit partners offer mobile apps on both iOS and Android platforms. Consider installing these on your smart phone or tablet so they are ready when you need them*:

- ☐ VbasMobile (summary of medical, dental and vision plans in which you are enrolled through BSSP)
- ☐ Anthem Anywhere (medical)
- ☐ Delta Dental (dental)
- ☐ VSP (vision)
- ☐ Healow (Health and Wellness Centers)
- ☐ MDLive (virtual office visit)
- ☐ Optum Bank (HSA)
- ☐ Costco (most mail order maintenance medications)
- ☐ GoodRx (prescription savings tool)
- ☐ Advance Medical (expert medical opinion service)

*Generally, you must register your account(s) using a web browser (Chrome, Internet Explorer, etc.) prior to accessing your accounts through the app on your mobile device.





Maximizing Your Benefits continued…

Consider these options for reducing your out of pocket costs.

UTILIZE MORE EFFICIENT MEDICAL CARE

- ☐ Become a patient of the Health and Wellness Centers
- ☐ Be a medical consumer
  - Utilize only network providers
  - Estimate your cost (www.anthem.com/ca/sisc)
  - Use Ambulatory Surgery Centers rather than outpatient hospital facilities. See Benefit Restrictions and Limitations for more information.
- ☐ Take generic prescriptions whenever possible. Generic copayments are:
  - $0 at Costco for non-HSA plans
  - $7 or $10 at other retailers except Walgreen's
  - For HSA plans, prescriptions are subject to the deductible. You will pay the full cost of the prescription until your deductible is met. Generic medications will always be less than brand name medications.
- ☐ Fill you maintenance prescriptions at Costco or via mail order.
- ☐ When you can't access the Health and Wellness Center but have an episodic or urgent medical need, try MDLIVE. Your cost is $5 (or $40 for HSA plans).

Maximizing Your Benefits continued…

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

AN APPLE A DAY

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

USING THE EMERGENCY ROOM

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call the Health and Wellness Center, your doctor or go to an urgent care clinic. You'll save a lot of money and time.

BE MED WISE!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

Planning for Retirement

WHOM TO CALL

As you approach retirement, meet with a district representative to determine …

- What BSSP benefits are available to you,
- How long benefits are available to you and your dependent(s), and
- The cost of those benefits.

Eligibility for post-retirement benefits varies by district, bargaining unit and other factors.

RETIRING PROR TO MEDICARE ELIGIBLITY – WHAT DOES NOT CHANGE

- The plans in which you may enroll (prior to becoming eligible for Medicare). You may elect a different plan at retirement, if allowed by your bargaining unit.
- You continue to be eligible for services at the Health and Wellness Centers when covered under a BSSP medical plan.
- You have the same opportunity to change your plan elections during the annual Open Enrollment period.

RETIRING PROR TO MEDICARE ELIGIBLITY – WHAT DOES CHANGE

- The cost of coverage: The cost of coverage varies based on the number of family members covered with the retiree. *See your Plan Menu for details.*
- Participation requirements: There is no requirement to continue participation at retirement, however, you may not return after a break in coverage.
- You may drop any line of coverage (medical, dental and/or vision) and continue with others, if allowed by your district.

RETIRING AT OR AFTER MEDICARE ELIGIBILITY

Eligibility for Medicare occurs at age 65 or based upon determination of a disability by Medicare.

- You are eligible for Medicare effective the:
  - 1st of month in which you turn 65, or
  - 1st of month prior to the month in which you turn 65, if your birthday is on the 1st
  - 1st of the 23rd month following disability
- Contact the Social Security Administration 2-3 months prior to your anticipated retirement date to begin the Medicare enrollment process.
- Confirm with your district if you and/or your spouse are eligible to continue coverage after reaching Medicare eligibility and what plans/enrollment options you may select from.
- Medicare limits enrollment to only one supplement or Advantage plan; double coverage is not permitted.
- Generally, once you reach Medicare eligibility, you are no longer eligible for services at the Health and Wellness Centers.

Contact Medicare 2-3 months before you turn 65!

Failure to enroll in Medicare Part A and B may lead to penalties on your Medicare premium and leave you responsible for up to 80% of the charges Medicare would have paid.

Who Can You Cover?

WHO IS ELIGIBLE?

You can enroll the following family members in your medical, dental and vision plans:

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- Your registered domestic partner is eligible for coverage if you have filed a Domestic Partner Affidavit with the Secretary of State. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partnership. Any premiums for your domestic partner paid for by your employer are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis. Contact your tax advisor about your domestic partner's tax dependent status and advise your employer if your domestic partner is a tax dependent.
- Your children (including your spouse/domestic partner's children):
    - Under the age of 26 are eligible to enroll in coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and a federal tax dependent.
    - Guardian children under the age of 18 are eligible to enroll in coverage with current court documents certifying guardianship status.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Parents, grandparents, siblings and common-law spouses are not eligible for coverage.

WHEN CAN I ENROLL?

Coverage for new employees begins on the 1st of the month following date of hire. New employees who do not make an election within 31 days of becoming eligible will automatically be enrolled in the Waiver Fee plan (or MEC HSA plan, if Waiver Fee plan is not available).

Make sure to notify your employer's Human Resources/Benefits office within 31 days of a qualifying life event and a need to make a change (add or drop) to your coverage election. Life events include, but are not limited to:

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for other healthcare coverage
- Marriage
- Divorce

OPTING OUT OF COVERAGE

Full-time employees may opt out of medical and prescription coverage, and any premium charges, with proof of enrollment in Tri-Care, Medicare, Medi-Cal or subsidized enrollment in Covered California.

Who Can You Cover? continued …

DO YOU HAVE DOUBLE COVERAGE?

Here are some things to consider when both spouses are covered as employees within BSSP:

- Medical:
    - One spouse may elect the MEC HSA plan and receive all the benefits of the other spouse's medical and prescription benefit.
    - Two medical plans will coordinate to the richest benefit of both plans.
    - Generally, a lesser plan will not reduce the deductible or out of pocket limits of a richer plan.
    - Claims must be submitted to the primary plan before the secondary plan. An employee is primary on his/her own plan; secondary on his/her spouse's. Generally, children are primary on the parent with the earliest birth date in the calendar year.
    - Each claim will apply to the deductible and out of pocket limits of both plans.
    - In the rare instance of high claims during a calendar year, a benefit reserve on the lower plan may reduce out of pocket costs under the richer plan. For this reason, consider enrolling children under each parent. You can verify under which parent the children are covered by logging into the benefits portal at www.vbas.com. See Changing Your Benefits Through Vbas for more information on logging into Vbas and Open Enrollment for information on adding dependents to coverage.
    - Although a full-time employee may not decline BSSP's medical, dental or vision coverage, BSSP does provide a 25% discount to the monthly medical premiums when each spouse is enrolled as an employee and a spouse in a composite-rate plan. *Enrollment in the Waiver Fee plan disqualifies both spouses from receiving the 25% discount.*
- Pharmacy: You are encouraged to submit prescription claims to the richest prescription benefit of the two plans. One plan will not pay for the copayment of the other plan.
- Dental: Both plans will pay to the limit of each plan, not to exceed the allowed amount of the claim.
- Vision: Benefits on each plan may be accessed separately or combined to offer a higher allowance towards a single benefit.

Children also benefit from double-coverage of parents who are not married, although there is no double-coverage premium discount.

Who Can You Cover? continued …

WAIVER FEE

The Waiver Fee is an opt-out of medical and prescription coverage available to any full-time employee at a cost equal to the MEC HSA premium. For a double-covered employee or family, the Waiver Fee provides the convenience of being enrolled in only one plan, with one benefit card to carry and only one Explanation of Benefits (EOB) for each claim.

Why the Waiver Fee is not recommended:

- Under the medical plans' benefit reserve provision, with very large medical claims the lower plan may have sufficient savings to offset the member's out of pocket costs on the richer coverage. This typically happens only with a high cost surgery, etc.
- The Waiver Fee also disqualifies each spouse from the 25% discount for double coverage within BSSP.
- Enrollment in the Waiver Fee exempts the member and any dependents from the opportunity to receive services at the Health and Wellness Centers. If the member is covered under another BSSP+SISC medical plan as a dependent, access to the Health and Wellness Centers is available under the other coverage.

Benefit and Election Cycles

Open Enrollment: Annually from mid-April through June27th

Plan Elections: October 1 through September 30

Plan Limits: Medical plan limits accumulate on a calendar year basis, from January 1 through December 31. *Non-HSA plans carryover amounts applied to the deductible between October 1 and December 31 to the following calendar year's deductible.

Dental plan benefit maximums accumulate from January 1 to December 31. Orthodontia benefits are a lifetime maximum.

Vision benefits are available 12- or 24-months from the last date of the same service.

If you change your elected benefit, the amount accumulated towards your benefit limits or maximums as of September 30 may carry over to your new benefit effective October 1.

When you move from a non-HSA plan to another non-HSA plan (i.e. 80% M $40 to 80% J $30), or an HSA plan to another HSA plan (i.e. MEC HSA to HSA B), the amounts accumulated toward your medical and prescription deductibles and out of pocket maximums through September 30 ***WILL*** be applied to your elected benefit as of October 1.

When you move from an HSA plan to a non-HSA plan (i.e. MEC HSA to 80% J $30), the amount accumulated toward your deductible and out of pocket maximums for medical claims incurred through September 30 ***WILL*** be applied to your elected benefit as of October 1. Prescription claims are not eligible to transfer. Depending on your accumulator totals, you may or may not have any additional deductible and/or out of pocket amount to meet as of October 1. Your limits will reset on January 1 when the annual plan limit cycle begins.

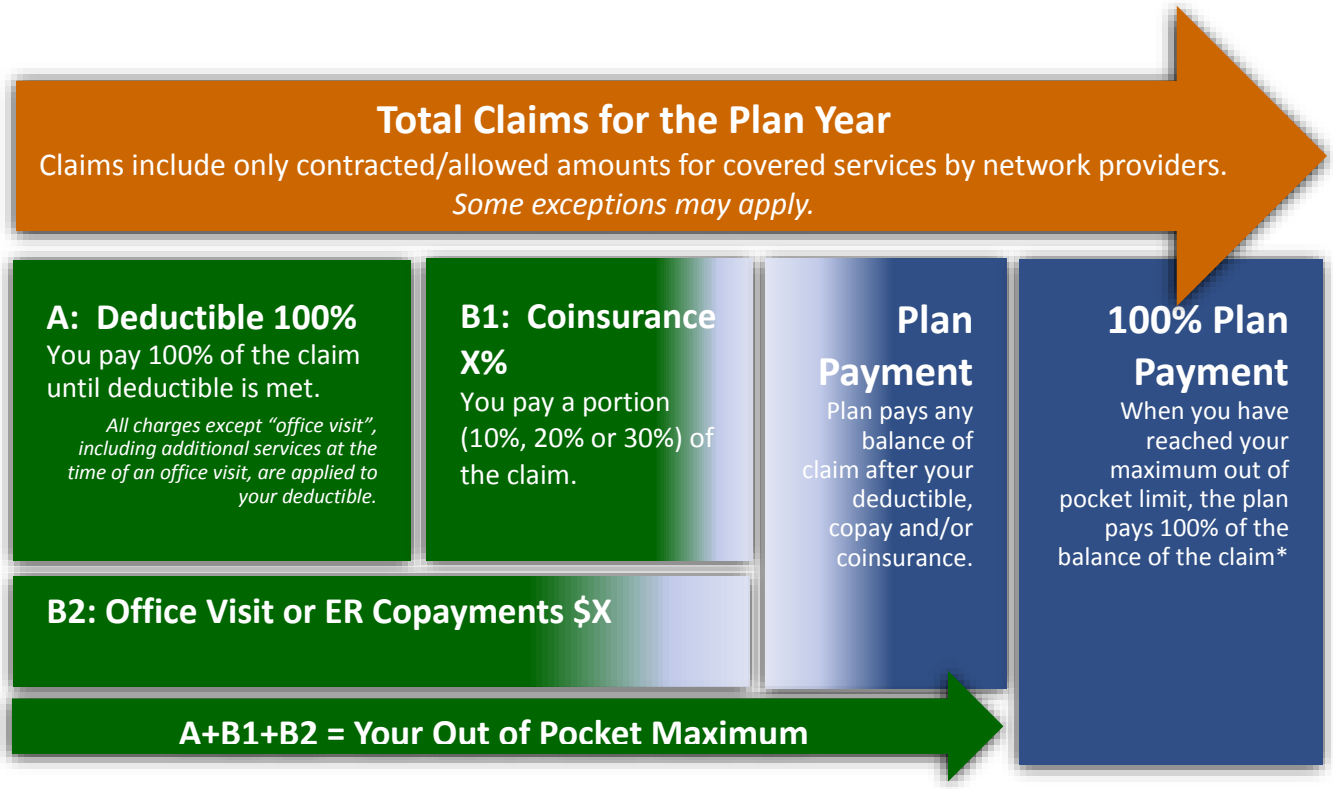
When you move from a non-HSA plan to an HSA plan (i.e. 80% J $30 to MEC HSA), the amounts accumulated toward your deductible and out of pocket maximums through September 30 ***WILL NOT*** be applied to your elected benefit as of October 1, in accordance with IRS regulations. Your HSA plan deductible and out of pocket limits will reset to $0 on October 1 and again on January 1 when the annual plan limit cycle begins.

Deductibles, Copays and Out of Pocket Limits

When you receive medical services under your plan, you may be responsible to pay a deductible, copayment and/or coinsurance until your out of pocket maximum is reached. The out of pocket limits under your plan consider only the claims for network providers, although some exceptions do apply.

- Deductible: At the beginning of the plan year, you pay 100% of each claim until your deductible is met.
- Coinsurance: Then, you pay coinsurance, which is a cost share between you and the plan. On most plans, you pay 20% and the plan pays 80%, although some plans have a 10%/90% or 30%/70% cost share.
- Copayments: With non-HSA plans, the office visit charge for a doctor or mental health professional bypasses your deductible and coinsurance responsibility so that you only pay a flat dollar fee for the office visit.

You may be billed for a facility charge, lab tests or other services also provided at the time of your office visit and those charges will be subject to your deductible or coinsurance responsibility.



Deductibles, Copays and Out of Pocket Limits continued …

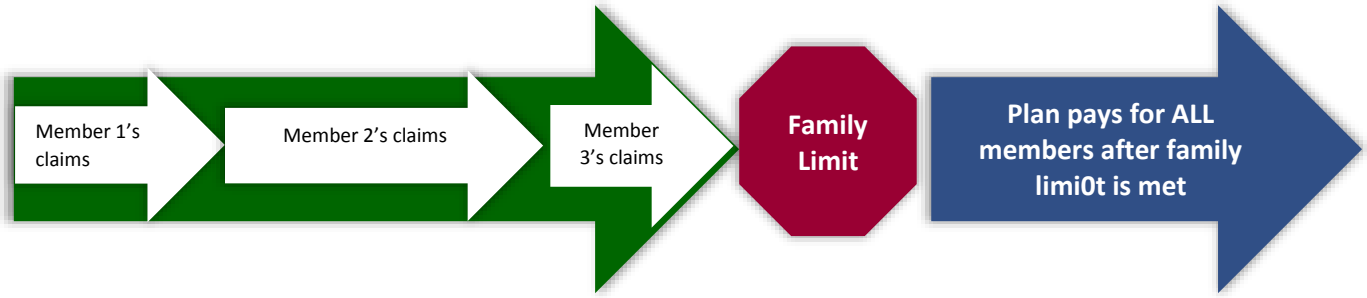
INDIVIDUAL AND FAMILY OUT OF POCKET MAXIMUMS

Each plan has both individual and family deductibles and out of pocket limits. As family members incur claims, claims are applied to both the family's as well as the individual's limits. If the family limit is reached before any individual's limit is reached, the plan will pay as if everyone has reached their individual limit.

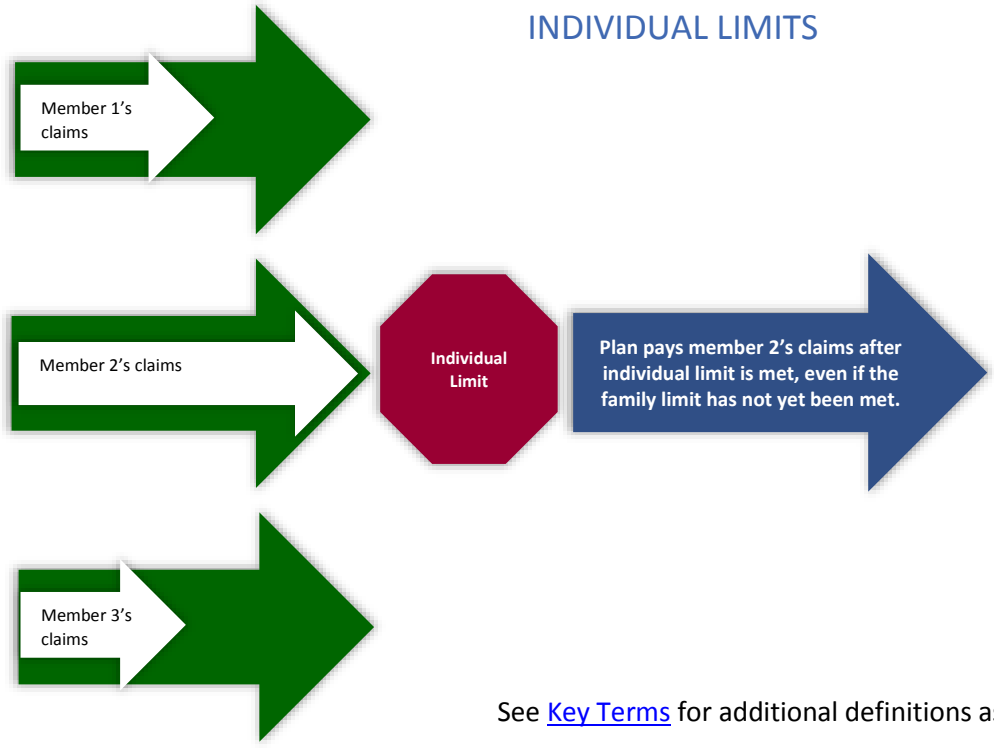
Within a plan year, you will never pay more than the individual deductible or out of pocket maximum for any one family member, nor the family deductible or out pocket limit for all family members, combined.

Non-HSA plans have separate out of pocket maximums for both medical and prescription claims. HSA-eligible plans have combined medical and prescription deductibles and out of pocket limits.

FAMILY LIMITS



INDIVIDUAL LIMITS



See Key Terms for additional definitions associated with your benefits.

Selecting your Medical Plan

There are many differences between your medical plan options, but the network providers, covered procedures and covered prescriptions are the same on every Anthem plan. The only differences between the plans are the monthly premiums and the amount you will pay out of pocket for a medical claim or prescription.

Same across all Plans	Different between Plans
• Network providers and facilities • Covered procedures • Prior authorization criteria • Preventive care paid at 100% @ network providers • Prescription formulary • Coverage away from home	• Monthly premium • Payroll deduction or cash in lieu • What you pay for a claim (deductible, copays and coinsurance)

When selecting your plan, consider your response to these questions:

- Can you save some of the difference in the monthly premiums to pay for higher out of pocket costs when you have a claim?
- How often do you use the plan and for what types of services do you use it?
- What types of prescriptions do you have?

BSSP's Plan Cost Estimator will highlight the medical cost differences between your plan options. You can download the Plan Cost Estimator at www.bsspjpa.org.

HOW DOES THE PLAN COST ESTIMATOR WORK?

The Plan Cost Estimator compares the total cost of each plan available to you based on the following factors:

- Employer contribution
- Your contribution towards each plan (via payroll deduction) or the amount of cash in lieu you may receive (if offered)
- Your family's claims for preventive care, Health and Wellness Center, MDLive virtual office visits, chiropractor, acupuncture and other office visits, emergency room care, surgeries, in-patient hospital admissions and prescriptions

DO YOU HAVE DOUBLE COVERAGE?

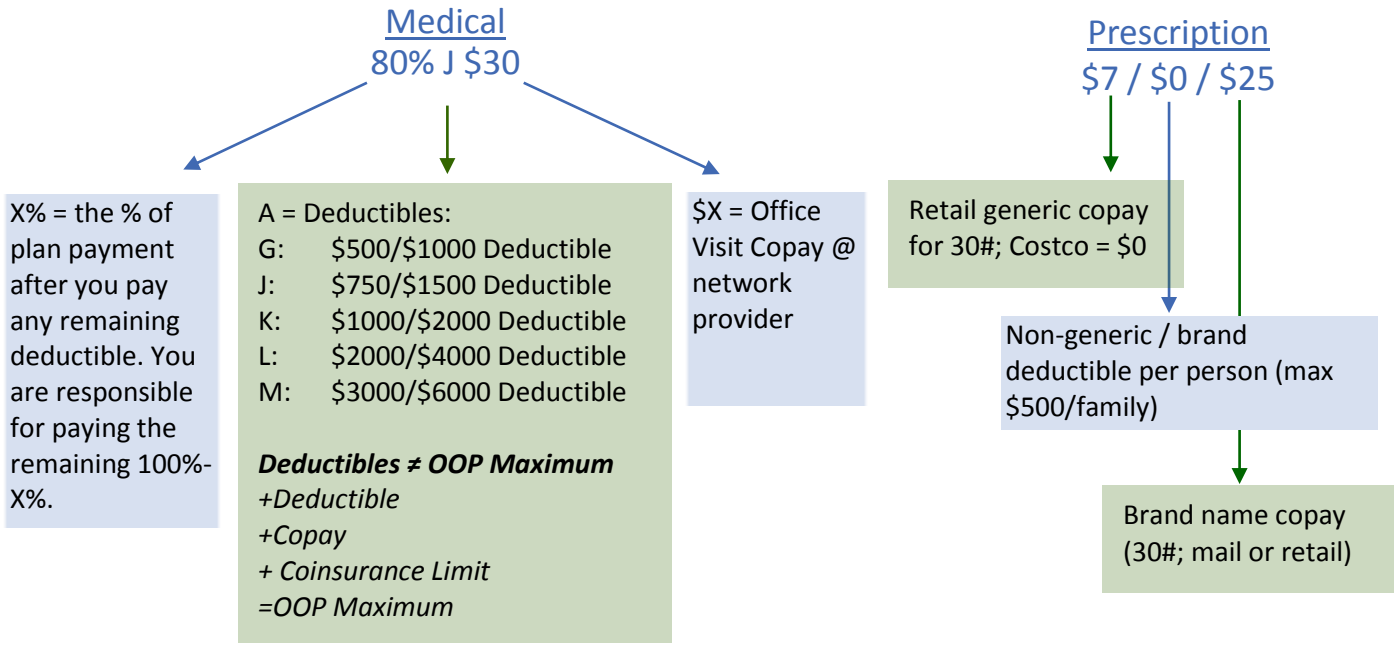
See Do You Have Double Coverage for more information.

Medical and Prescription Plans

The following pages include an overview of the Anthem medical plans available. Pharmacy benefits are also listed for each plan option and are administered by Navitus. See Selecting Your Medical Plan for more information on how to make your selection.

ANTHEM MEDICAL/RX PLAN NAMES

Anthem plan names include information about a lot of details of the plan.



Medical and Prescription Plans continued …

BENEFIT RESTRICTIONS AND LIMITATIONS

Your Anthem medical and Navitus prescription benefit plans provide broad coverage. However, the cost of health care has been increasing at unstainable rates. BSSP's medical benefits partner, SISC, continually evaluates ways to keep benefits affordable without impacting access to high quality and safe care. Incenting the appropriate use of certain facilities for certain surgeries and procedures, and limiting certain benefits to prior authorization, helps curb out-of-control costs without any reduction in the quality of care.

Out of pocket limits apply for certain non-emergency surgeries and ONLY when performed at selected network facilities. Before scheduling your procedure or surgery, discuss these benefit limitations with your provider to ensure your costs are limited to the out of pocket limits of your plan. *Butte County facilities are listed below; call Member Services (Coastal TPA) at (800) 564-7475 for other covered facilities near you. Certain exceptions apply.*

VALUE-BASED SITE OF CARE BENEFIT

The maximum benefit amount for the 5 common procedures listed below is limited when performed at an in-network outpatient hospital. At an in-network outpatient hospital, you will be responsible for facility charges above the maximum benefit, beyond your plan's out of pocket limits. This limitation applies to the facility fee only, fees paid to physicians or any other practitioners who assist in the procedure are not affected by this change.

Arthroscopy ($4,500 maximum benefit)	<u>Butte County Ambulatory Surgery Centers</u> Advanced Eye Surgery Center Eye Life Institute Chico Surgery Center Skyway Surgery Center
Cataract Surgery ($2,000 maximum benefit)	
Colonoscopy ($1,500 maximum benefit)	
Upper GI Endoscopy w/ Biopsy ($1,250 maximum benefit)	
Upper GI Endoscopy ($1,000 maximum benefit)	

- If you use an <u>Ambulatory Surgery Center (ASC)</u> for these procedures, there is **<u>NO</u>** benefit change. You will only be responsible for the regular deductible and coinsurance amounts.
- If you use an <u>in-network outpatient hospital facility</u>, you will be responsible for the regular deductible and coinsurance **<u>PLUS</u>** any amount by which the hospital's facility charge exceeds the maximum benefit above. Some exceptions may apply; consult with your provider and Anthem.

In the following cases, an exception may be granted:

- If your physician provides clinical justification for using a hospital.
- If you live more than 30 miles from an ASC.
- If your procedure cannot be scheduled in a medically appropriate timely manner due to available ASCs not having capacity.
- In an emergency.

The physician performing the procedure must apply for one of the exceptions above, in advance of your procedure, by contacting Anthem Provider Services directly.

Medical and Prescription Plans continued …

BLUE DISTINCTION REQUIREMENTS

Benefits for these non-emergency surgeries are restricted to facilities with certain distinctions. Joint replacement and spinal fusion surgeries may also be available through Carrum Health (888-855-7806) for $0 out of pocket on non-HSA plans.

- Hip or Knee Replacement, Cervical or Lumber Spinal Fusion: Anthem Blue Distinction+ at Enloe Medical Center
- Bariatric Surgery: Anthem Blue Distinction at Enloe Medical Center
- Organ and Tissue Transplant: Centers of Medical Excellence (see Anthem website for CA locations)

Before scheduling any of the procedures listed above, be sure to confirm if your surgeon operates at a hospital with the required distinction for your procedure. Often, Blue Distinction hospitals will have a program director on staff that can assist with finding surgeons that are a part of their program.

In rare instances exceptions may apply. Some examples include:

- Additional health complications such as cancer
- Patient is under the age of 18
- SISC is secondary to other primary benefits
- Patient lives outside of California

OTHER LIMITATIONS

- Non-Network Providers - The following services are not covered by the plan when obtained from a non-network provider:
    - Diagnostic services (x-rays, radiology, lab work, other tests)
    - Physical Medicine (physical therapy, occupational medicine, chiropractic services)
    - Durable Medical Equipment and Medical Supplies
    - Exceptions to this provision:
        - Emergency services
        - Labs or tests performed within a network hospital
        - Anesthesiology services from within a network hospital
- Acupuncture: Each covered member is limited to 12 visits per year.
- Physical / Occupational / Speech Therapy and Chiropractic Care: After an initial five visits, all visits are subject to medical necessity review by American Specialty Health.
- Prescription Benefits: Walgreen's is not a network pharmacy.

Medical and Prescription Plans continued …

TRAVEL COVERAGE

- Outside of California: Out of state coverage is coordinated by Anthem's BlueCard (BC) program. If you are traveling outside California, and need health care because of a sudden non-emergency illness or injury, call the Coverage While Traveling number on the back of your member ID card, 1-800-810-BLUE. The BC Access Call Center will tell you if there are doctors or hospitals in the area that can give you care. You may also access the information through www.anthem.com/ca/sisc.

- Out of the Country: When traveling out of the country, the Blue Cross Blue Shield Global Core program covers inpatient and emergency care services from many international providers. To access benefits, simply present your Anthem Blue Cross ID card when you receive services from a participating provider. Blue Cross Blue Shield Global Core providers will not require a payment from you at the time of your inpatient treatment except for the out of pocket expenses (non-covered services, deductible, co-payment and co-insurance) you normally pay. The hospital should submit a claim on your behalf. Doctors and non-network providers will require payment upfront. You will complete the Blue Cross Blue Shield Global Core claim form and submit with your bills for reimbursement. For updated information on international network providers, visit their website at www.bcbsglobalcore.com. You can also get information on worldwide providers by calling BC Provider Access toll-free at 1-800-810-BLUE. Coverage for services from international providers may be limited. If you are unable to access a participating international provider and you require care for an emergency or urgent condition, go to the nearest provider and get treated. Please notify Anthem Blue Cross as soon as possible if you are admitted into a hospital. Ask for your claims and medical records to be provided to you in English, and submit them to Anthem for processing.

- Emergency Coverage: It is to your benefit to visit a network provider to save money even when you are traveling. If you are traveling in the state of California and need emergency care at an emergency facility, you will be charged a $100 ER copayment and any applicable deductible and/or coinsurance whether you have services in or out of network. However, you may be billed by the provider for any charges over the customary and reasonable rate if services are obtained out of network. This applies as well if you are traveling outside of California. In an emergency, you should call 911 or seek immediate treatment at the nearest facility. If admitted to the hospital directly from the emergency room, you will not be charged the emergency room copay. Also, if you are admitted to a hospital, you or a family member should call the Customer Service number on your ID card as soon as your medical condition permits. The hospital and Anthem Blue Cross will work together to coordinate your care.

Medical and Prescription – Anthem / Navitus

This is only a brief overview of your plan's benefits. For more detailed information about the benefits in your plan, please refer to your Evidence of Coverage (EOC; www.bsspjpa.org), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

Biggs Class & Conf

Below is a brief summary of benefits for in-network benefits, only. Review the benefits summaries or plan booklets for details, limitations and exclusions. This summary is for informational purposes, only. It does not amend, extend or alter the current policy in any way. In the event information in this summary differs from the Plan Document, the Plan Document will prevail.

Anthem PPO[1]

	Medical RX	80% J $30 $7/$0/$25	80% M $40 $7/$0/$25	HSA B[2] HSA	80% M $40 $10/$200/$35	MEC HSA[2] HSA
A3R2	Active Single	$841	$699	$696	$663	$533
	Active 2-Party	$1,407	$1,162	$1,158	$1,100	$877
	Active Family	$1,771	$1,460	$1,452	$1,381	$1,097
	Retiree Single	$1,216	$1,008	$992	$953	$754
	Retiree Family	$1,713	$1,407	$1,432	$1,338	$1,081
MEDICAL						
Calendar Year Out of Pocket Maxium[3] (Individual / Family) = Deductible + Coinsurance + Copayments		**$3000 / $6000**	**$4000 / $8000**	**$5000 / $10000**	**$4000 / $8000**	**$6350 / $12700**
Calendar Year Deductible Member pays 100% of the network rate for all services until the individual / family deductible is met. Preventive care and physician office visits bypass the deductible.		$750 / $1500	$3000 / $6000	$3000 / $5200	$3000 / $6000	$5000 / $10000
4th Quarter Carryover?		Yes	Yes	No	Yes	No
Coinsurance After the deductible is met, member pays X% of network rate for services until the Out of Pocket Maximum is reached. Coinsurance applies to all covered services not listed under "Copayments".		20%	20%	10%	20%	30%
Copayments Member pays a set fee and the deductible does not apply, unless stated otherwise, until the Out of Pocket Maximum is reached. Office visits (physician/mental health, only; facility, lab, diagnostic and other charges subject to deductible)		$30	$40	10% (after deductible)	$40	30% (after deductible)
HWC NP/PA-C/Lab Services		$0	$0	$25 (no ded)	$0	$25 (no ded)
ER ($100 waived if admitted)		$100 + 20%	$100 + 20%	$100 + 10%	$100 + 20%	$100 + 30%
MD Live		$5	$5	$40	$5	$40
Preventive Care Physical exams & screenings tests w/ network provider. *Includes all Preventive Services required by law.*		Paid at 100%	Paid at 100%	Paid at 100%	Paid at 100%	Paid at 100%
PRESCRIPTION						
Calendar Year Out of Pocket Maxium[3] (Individual / Family; in addition to medical, above)		**$1500 / $2500**	**$1500 / $2500**	**See medical**	**$2500 / $3500**	**See medical**
Annual Deductible (brand, only)		$0	$0	See medical	$200/$500	See medical
Copayments				Copay applies after deductible		Copay applies after deductible
HWC (preventive/generic/brand)		$0 / $4 / $8	$0 / $4 / $8	$0[3]	$0 / $4 / $8	$0[3]
Costco or Mail up to 90# (generic / brand)		$0 / $60	$0 / $60	$0[3] /$90[3]	$0 / $90	$0[3] /$90[3]
Specialty 30#		$25	$25	$35[3]	$35	$35[3]
Retail[4] 30# (generic / brand)		$7 / $25	$7 / $25	$9[3] / $35[3]	$10 / $35	$9[3] / $35[3]

[1] *Anthem plans have a separate Out of Pocket (OOP) maximum for both medical and prescription for non-HSA plans. Generally, non-network claims do not apply to limits.*

[2] *HSA compliant plans are subject to legislative and regulation changes throughout the year.*

[3] *Copayment applies AFTER deductible is met.*

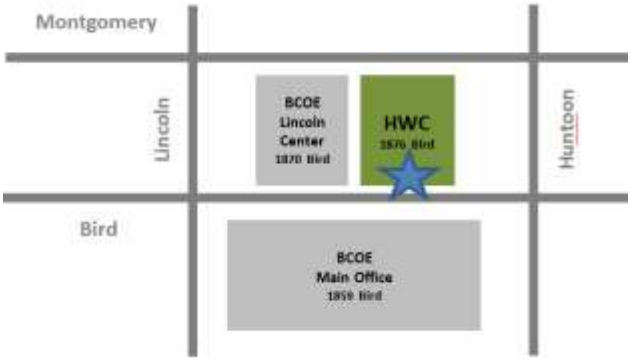
[4] *Prescriptions filled at Walgreen's are not covered.*

Health and Wellness Centers

Visit the Health and Wellness Centers conveniently located in Chico and Oroville. Both offer extended hours, the same services and dispensary items. The HWC staff are dedicated to you and your dependents. Services and benefits include:

- Preventive, primary and acute care
- Wellness services
- Fast and easy access
- Served within 10 minutes of appointment time
- Onsite lab services, including requests from outside providers (limitations may apply)
- Onsite prescription dispensary
- Non-HSA plans: all services are free and prescriptions dispensed are $4 or $8
- HSA plans: Non-preventive office visits and outside labs are $25, including prescriptions dispensed at the time of the office visit

	Chico	Oroville
Monday	8AM-7PM	8AM-6PM
Tuesday	6AM-7PM	8AM-6PM
Wednesday	7AM-7PM	7AM-5PM
Thursday	7AM-7PM	7AM-5PM
Friday	7AM-5PM	Closed
Saturday	9AM-1PM	Closed



Access to the Health and Wellness Centers is limited to those enrolled on Anthem plans.

Pharmacies

COSTCO PHARMACY

On non-HSA plans, you receive free generic medications at Costco retail pharmacies and through mail order, too! This includes 90-day prescriptions and supplies. You can also use your 90-day prescription to start mail order service online at www.costco.com/home-delivery or by calling 800-607-6861. **You do not have to be a Costco member to use the Costco retail pharmacy**. Just tell the associate at the front door you are going to the pharmacy.

1. Take your prescription for generic medication to a Costco pharmacy
2. Present your BSSP+SISC Anthem insurance card
3. Get your generic medication with a **$0 copay** on non-HSA plans for up to 90-day supply

Copayments of $7 or $10 apply on narcotics and some cough medicines on non-HSA plans. On HSA plans, all prescriptions are subject the plan's deductible. Brand name medications are also available at Costco. Brand name copay applies.

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

OTHER RETAIL PHARMACIES

The following are available at most national pharmacy chains and local pharmacies, excluding Walgreen's.

30-day supply

- Deductible applies on HSA plans and for brand name prescriptions on non-HSA plans with a prescription deductible.
- $7 or $10 (non-HSA plans) for generic medications
- $25 or $35 (non-HSA plans) for brand name medications

Specialty 30-day supply

- After deductible (if applicable), copayment applies

Advance Medical: Expert Medical Opinion

When it comes to making sure the medical treatment you get is the medical treatment you need, the Advance Medical Expert Medical Opinions program is your best advocate. The program will help you find comfort and clarity whenever you need to better understand the best options for your care. Advance Medical gives you access to the world's finest minds when determining the best course of treatment for your medical situation. Experts come from all over the globe and are chosen specifically to address your concerns. You will work directly with a doctor who will serve as your case manager and will guide you to the answers that you need. Whenever you're concerned about a treatment or diagnosis, feel that you are not clear on what to do next, or wonder if you have all the information you need to be comfortable making a decision, call Advance Medical.

Ask them anything 24 hours a day/7 days a week. It's free, it's easy and it's 100% confidential.

For more information or to get started, please visit www.advance-medical.net/sisc or call 855-201-9925.

MDLIVE: Virtual Office Visit

MDLIVE provides all covered members with access to board-certified doctors/pediatricians who can answer their health-related questions conveniently over the phone, via online video or secure e-mail. Licensed behavioral health professionals also available via secure video. This program is available 24/7, 365 days a year including holidays. The service is secure, confidential and compliant with all medical privacy regulations.

To begin using this benefit, members must first register by calling MDLIVE at 800-657-6169 or by going online to www.mdlive.com/sisc. Members will need to have their member ID number and the name, address and phone number of the covered member who needs medical assistance. The main subscriber on the policy must be registered before covered dependents can register and access care.

General Medical Conditions
$5 copay ($40 for HSA plans)

- Acne
- Allergies
- Cold/flu
- Constipation
- Diarrhea
- Ear problems
- Fever
- Headaches
- Insect bites
- Nausea/Vomiting
- Pink Eye
- Rashes
- Respiratory problems
- Sore throats
- Urinary problems/UTI
- And more!

Behavioral Health
$5 copay (Deductible/coinsurance for HSA plans)

- Addictions
- Bipolar disorders
- Child & adolescent issues
- Eating disorders
- Gay/Lesbian/ Transgender issues
- Grief and loss
- Life changes
- Men's/Women's issues
- Panic disorders
- Parenting issues
- Postpartum depression
- Stress
- Relationship/marital issues
- Trauma and PTSD
- And more!

Solera4Me Diabetes Prevention Program

Solera is a 16- week, cutting edge program that can help you lose weight, adopt healthy habits and significantly reduce your risk of developing diabetes. It's available at no cost to members that qualify and are enrolled in an Anthem plan.

You'll be able to choose from an array of national and local programs, like WeightWatchers, Jenny Craig, Retrofit and HealthSlate. While each of these programs may differ, most include:

- Tools like a wireless scale or activity tracker
- Access to a personal health coach
- Weekly sessions
- A small group for support.

Find out if you qualify by taking a 1-minute quiz at www.solera4me.com/sisc.

Carrum: Surgery Benefit

Carrum Health is a carved-out surgery benefit available to you! Covered surgeries provided through Carrum at Scripps Health in San Diego, California are covered at $0 under non-HSA plans and only subject to the deductible on HSA plans. A Care Concierge will coordinate all follow-up prior to your procedure. Each patient will receive personalized support and guidance from their Care Concierge.

Covered Surgeries:

- Hip replacement
- Knee replacement
- Cervical spinal fusion
- Lumbar spinal fusion

Optum Bank Health Savings Account

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

An HSA is a unique tax-advantaged account that can be used to pay for current or future healthcare expenses. When combined with one of the HSA plans, it offers savings and federal tax advantages that our other health plans cannot duplicate. With an HSA, employees will have:

- A pre-tax savings account they can use to pay for eligible medical expenses, like deductibles, coinsurance, prescriptions, vision and dental care.
- Unused funds that will roll over year to year. There is no "use it or lose it" penalty, and you keep your HSA even if you change employers.
- Potential to build more savings through investing. You can choose from a variety of HSA investment options through our HSA administrator, Optum Bank.
- Additional retirement savings. After age 65, funds can be withdrawn for any purpose without penalty but may be subject to income tax if not used for qualified medical expenses.

WHO IS ELIGIBLE TO PARTICIPATE?

To be eligible for our HSA, you must meet the following criteria:

- You must be enrolled in an HSA-eligible plan.
- You cannot have any other health coverage that is not an HSA plan, such as Medicare, TRICARE or other non-HSA-eligible coverage under your spouse or domestic partner.
- You cannot be actively serving in the military or have received Veterans Administration (VA) benefits within the past three months.
- You must be a U.S. resident.
- You cannot be claimed as a dependent on someone else's tax return.
- You generally cannot have another savings account that pays or reimburses for qualified medical expenses, such as the Health Care Flexible Spending Account (FSA). However, having a Limited Purpose FSA is permitted for use in paying for dental and vision expenses.

HOW DOES IT WORK?

If you choose to participate in an HSA, you decide how much money you want to contribute per paycheck or each year (within IRS annual limits). However, you can increase or decrease your monthly contribution amounts anytime throughout the year. Once enrolled, you'll receive a special debit card from Optum Bank. This debit card can be used to pay for eligible medical expenses on the spot. A $2.50 service fee will be withdrawn monthly from your account; that fee is waived when your balance is over $5,000.

Employee Assistance Plan

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through Anthem Blue Cross can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources.

WHO IS ELIGIBLE?

- Any employee, retiree or dependent covered under a BSSP+SISC medical plan
- Any part-time (non-benefited) employee or retiree of a BSSP-participating district/bargaining unit
- Any household member of above

HOW MANY VISITS ARE COVERED AND HOW MUCH DOES IT COST?

- 6 – 1 hour counseling sessions, per person, per incident, per year
- EAP visits are FREE!

WHAT DELIVERY METHODS ARE AVAILABLE?

- In Person
- Telephonic
- Virtual / Video

Help is available 24/7, 365 days a year by telephone at 800-999-7222. When calling in, you'll be asked…

- Your name
- Your Company Code (SISC)
- Name of your school district
- Other demographic information

An EAP representative will ask you questions to determine what type of services are needed (mental health, legal, financial) and what delivery method best suits your needs (in-person, telephonic or virtual sessions).

If you prefer to have an EAP representative schedule an appointment with a counselor for an in-person session, be sure to ask "Will you please make the calls for me".

If you prefer to schedule your in-person appointment, you'll be provided a list of EAP counselors in the geographical area requested. Take the list and begin calling counselors to find one you like and who can meet your scheduling needs. Just tell the provider that you're calling to schedule an EAP appointment.
If you prefer another therapist after the first meeting, call the toll free number back and EAP will set you up with another provider.

Other resources are available online at www.anthemeap.com. When you log in, enter SISC as your Company Code. For more information, visit www.bsspjpa.org. Click on "For Employees" and then the "Employee Assistance Program (EAP)" button.

Additional benefits are available through MDLIVE and your medical plan.

Dental

Regular visits to your dentist can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Butte Schools Self-Funded Programs provides you with comprehensive coverage through Delta Dental of California. Your employer will provide you with separate information about the amount the district will contribute towards your plan's monthly rate.

DO YOU HAVE DOUBLE DENTAL COVERAGE?

If both spouses are covered as employees under a Delta Dental plan, you are encouraged to cover each as a spouse under the other's plan; children are encouraged to be covered under both as well. Both plans will pay to the limit of each plan, not to exceed the allowed amount of the claim.

This is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Evidence of Coverage (EOC; www.bsspjpa.org), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

	Plan 1	Plan 8	Plan 10	Plan 12
Monthly Rate	**$63**	**$104**	**$113**	**$130**
Network	**PPO Only**	**PPO + Premier**	**PPO + Premier**	**PPO + Premier**
Calendar Year Plan Maximum	$1,200/individual PPO $1,000/individual non-network	$2,200/individual PPO $2,000/individual Premier & non-network	$2,200/individual PPO $2,000/individual Premier & non-network	$3,000/individual PPO & Premier $2,000/individual non-network
Calendar Year Deductible	$50 / individual $150 / family	$0 / individual $0 / family	$0 / individual $0 / family	$0 / individual $0 / family
Cleanings	3 / calendar year	3 / calendar year	3 / calendar year	3 / calendar year
Diagnostic & Preventive	Plan pays 100%	Plan pays 70% - 100%	Plan pays 70% - 100%	Plan pays 70% - 100%
Basic Services Fillings Root Canals Periodontics	Plan pays 80%	Plan pays 70%-100%	Plan pays 70%-100%	Plan pays 70%-100%
Major Services	Plan pays 50%	Plan pays 70%-100% (prosthodontics are 50%)	Plan pays 70%-100% (prosthodontics are 50%)	Plan pays 70%-100% (prosthodontics is 50%)
Orthodontic Services Orthodontia Lifetime Maximum	Not covered Not applicable	Not covered Not applicable	Plan pays 50% $2,000	Plan pays 50% $2,000

Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions. Your employer will provide you with separate information about the amount the district will contribute towards your plan's monthly rate.

DO YOU HAVE DOUBLE VISION COVERAGE?

If both spouses are covered as employees under a VSP plan, you are encouraged to cover each as a spouse under the other's plan; children are encouraged to be covered under both as well. Both plans will provide the limits of each plan which results in true double coverage and benefits.

This is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Evidence of Coverage (EOC; www.bsspjpa.org), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

	Plan 4	Plan 4X	Plan 8	Plan 8X
Monthly Rate	**$15**	**$26**	**$23**	**$34**
Examination				
Benefit	$10 copay then plan pays 100%	$10 copay then plan pays 100%	$10 copay then plan pays 100%	$10 copay then plan pays 100%
Frequency (last service date)	1 x every 12 months	1 x every 12 months	1 x every 12 months	1 x every 12 months
Materials	$10 copay then plan pays 100%	$10 copay then plan pays 100%	$10 copay then plan pays 100%	$10 copay then plan pays 100%
Eyeglass Lenses				
Single Vision Bifocal Trifocal	Basic lens combined with exam	Basic lens combined with exam	Basic lens combined with exam	Basic lens combined with exam
Enhancements				
Tints/Photochromic adaptive lenses	$0	$0	$0	$0
UV protection	$0	$0	$0	$0
Anti-reflective Coating	$40	$40	$40	$40
Standard progressive lenses	$0	$0	$0	$0
Premium progressive lenses	$95 - $105	$95 - $105	$95 - $105	$95 - $105
Custom progressive lenses	$150 - $175	$150 - $175	$150 - $175	$150 - $175
Frequency (last service date)	1 x every 12 months	1 x every 12 months	1 x every 12 months	1 x every 12 months
Frames				
Benefit	$250 allowance, $135 Costco allowance, plus a 20% savings on the remaining balance	$250 allowance, $135 Costco allowance, plus a 20% savings on the remaining balance	$250 allowance, $135 Costco allowance, plus a 20% savings on the remaining balance	$250 allowance, $135 Costco allowance, plus a 20% savings on the remaining balance
Frequency (last service date)	1 x every 24 months	1 x every 24 months	1 x every 12 months	1 x every 12 months
Contacts (Elective)				
Benefit	$150 allowance (copay waived; instead of eyeglasses)	$50 copay for fitting exam and annual supply of contacts	$150 allowance (copay waived; instead of eyeglasses)	$50 copay for fitting exam and annual supply of contacts
Frequency (last service date)	1 x every 12 months	1 x every 12 months	1 x every 12 months	1 x every 12 months

KidsCare

Up to age 18, children are eligible for an additional exam when needed, additional lenses with a minimum prescription change, and frames every 12 months (plans 4 and 4x).

For Assistance

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

Benefit	Provider	Phone Number	Website
Eligibility	Butte Schools Self-Funded Programs	530-879-7438 bssp@bsspjpa.org	www.bsspjpa.org
Health and Wellness Centers	Healthstat, Inc.	530-879-7582 C 530-532-5918 O	www.bsspjpa.org/health-and-wellness-center.html
Medical PPO	Anthem	800-564-7475	www.anthem.com/ca/sisc
Rx Administrator	Navitus (Anthem)	866-333-2757	https://members.navitus.com/
Mail Order	Costco Mail Order	800-607-6861	www.costco.com/home-delivery
Surgery Benefit	Carrum Health	888-855-7806	my.carrumhealth.com/sisc
Virtual Office Visit	MDLIVE	800-657-6169	www.mdlive.com/sisc
Dental	Delta Dental	800-765-6003	www.deltadental.com
Vision	VSP	800-877-7195	www.vsp.com
EAP	Anthem EAP	800-999-7222	www.anthemeap.com
HSA	Optum Bank	844-326-7967	www.optumbank.com
Expert Medical Opinion	Advance Medical	855-201-9925	www.advance-medical.net/sisc
Diabetes Prevention Program	Solera4Me	877-486-0141	www.solera4me.com/sisc

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 80%, you are responsible for paying the remaining 20% of the cost.

Copay - The flat-dollar fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out of pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The maximum dollar amount any one family will pay out in individual deductibles in a year. IMPORTANT: Individuals in a family only have to satisfy the individual deductible before benefits kick-in.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services.

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. Some out-of-network services are not covered.

Out of pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out of pocket Maximum – The most you would pay out of pocket for covered services in a year. Once you reach your out of pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

Key Terms continued…

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

Diagnostic and Preventive Services - Generally include routine cleanings, oral exams, x-rays, sealants and fluoride treatments.

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Annual Legal Notices

Medicare Part D Notice

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Butte Schools Self-Funded Programs has determined that the prescription drug coverage offered by the Butte Schools Self-Funded Programs 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.

Annual Legal Notices, continued…

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 Butte Schools Self-Funded Programs coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Important Note for Retiree Plans: Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage.

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

If you do decide to join a Medicare drug plan and drop your Butte Schools Self-Funded Programs prescription drug coverage, be aware that you and your dependents can only get this coverage back at Open Enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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

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

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

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

Contact the person listed below for further information.

You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Butte Schools Self-Funded Programs changes. You also may request a copy of this notice at any time.

Annual Legal Notices, continued…

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

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

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

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

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

Date:	April 1, 2019
Name of Entity/Sender:	Butte Schools Self-Funded Programs
Contact-Position/Office:	Christy R. Patterson
Address:	500 Cohasset Road, Suite 24, Chico, CA 95926
Phone Number:	(530) 879-7438

Annual Legal Notices, continued...

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (530) 879-7438.

Nondiscrimination and Accessibility Requirements Notice

Butte Schools Self-Funded Programs complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Butte Schools Self-Funded Programs does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Butte Schools Self-Funded Programs:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

Annual Legal Notices, continued…

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Butte Schools Self-Funded Programs health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Butte Schools Self-Funded Programs health plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Butte Schools Self-Funded Programs health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

Annual Legal 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 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at 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 January 31, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/ - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

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COLORADO–Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991 / State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/caremgt/index.htm Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov/agencies/dms/Pages/default.aspx Phone: 1-800-635-2570	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: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

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MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://www.medicaid.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Website: https://www.coverva.org/hipp/ CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

Notes