



Butte Schools Self-Funded Programs

Benefits Overview effective October 1, 2025

A Fresh Look at Benefits



BUTTE SCHOOLS
SELF-FUNDED PROGRAMS

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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.

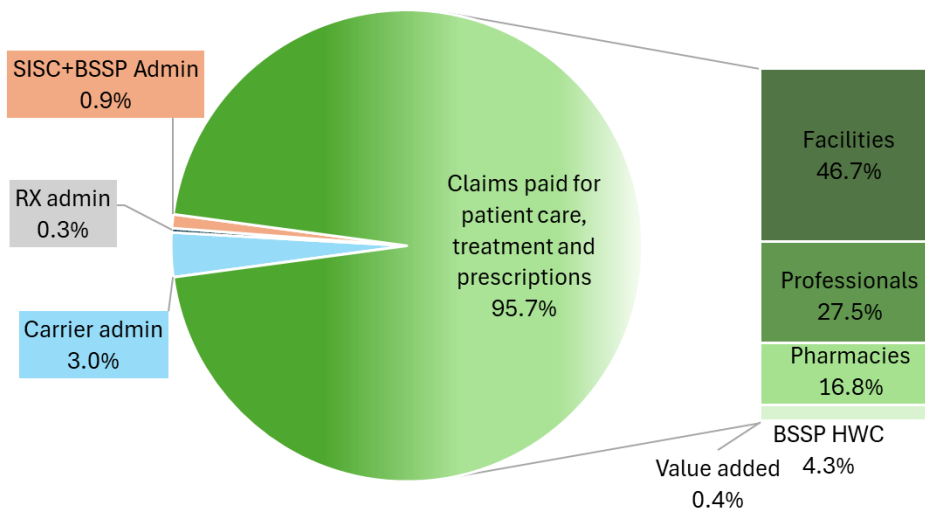
Understanding your BSSP Benefits

At Butte Schools Self-Funded Programs (BSSP), we believe that **you are our most important asset**. Your employer provides BSSP’s benefits program to help you and your family achieve and maintain good physical, emotional, and financial health.

Healthcare inflation continues to outpace most sectors of the economy, driving up the cost of your health insurance. This increase impacts both your personal budget and your employer’s. But where do the dollars paid into BSSP go??

BSSP’s medical, dental and vision benefits follow a non-profit model, collecting only what is necessary to cover plan benefits and administration costs. In fact, over 95% of every dollar paid into BSSP’s medical benefit goes directly to your healthcare providers – including hospitals, doctors and pharmacies.

How Are Your BSSP+SISC Premiums Spent?



This overview is designed to help you make the most of your benefits. Please review it carefully and reach out with any questions that are not answered here. You’ll find a list of plan contacts at the end of this summary.

While we strive to make this overview comprehensive, it does not provide every detail. For full plan information, refer to your plan Benefit Booklets or Summary Plan Descriptions (SPDs), which outline how all benefits are paid. You can download them at www.bsspjpa.org.

**The benefits in this summary are effective:
October 1, 2025**

Who Can You Cover?

WHO IS ELIGIBLE?

You may enroll the following family members in your BSSP benefit plans:

- Legally married spouse or registered domestic partner
- Biological, adopted, stepchildren or domestic partner's children up to age 26
- Legal Guardian Children up to age 18
- Children over age 26 who are disabled and an IRS tax dependent
- Children named in a qualified medical child support order (QMCSO)

Please refer to the Benefit Booklet/SPD available at www.bsspjpa.org 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 your date of hire. New employees who do not make an election within 31 days of becoming eligible will be default enrolled in the Waiver Fee plan for medical and the minimum dental and vision plan (subject to bargaining unit language).

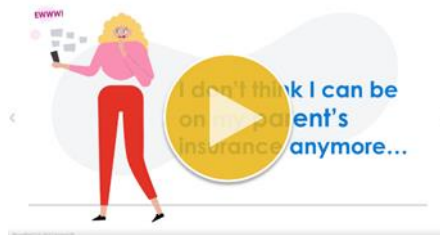
CHANGING YOUR BENEFITS – QUALIFYING LIFE EVENTS

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

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in your or a dependent's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan



You must submit any changes to your coverage within 31 days of the Qualifying Life Event. Otherwise, your changes can be made during the next Open Enrollment period.



Click to play video

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: You have two options to consider:

- **Waiver Fee Plan Option:** One spouse can elect the Waiver Fee plan and receive all the benefits of the other spouse's medical and prescription benefit. The Waiver Fee plan satisfies BSSP and SISC requirements for all full-time employees to participate in a medical plan, but without enrollment as a main subscriber. The spouse electing the Waiver Fee plan will receive benefits as the dependent on his/her spouse's plan.
- **Dual Main Subscriber Option:** For households where both spouses are enrolled as the main subscriber under their own plans:
 - Two medical plans will coordinate to the richest benefit of both plans.
 - Typically, a plan with lesser coverage will not reduce the deductible or out-of-pocket limits of a richer plan.
 - Claims must be submitted to the primary plan first, then the secondary plan. An employee is primary on his/her own plan and secondary on his/her spouse's. Children are primary on the plan of the parent whose birthday comes first in the calendar year. You can verify under which parent's plan covers your children by logging into your secure benefits portal at myhealthbenefits.com.
 - Each claim will apply to the deductible and out-of-pocket limits of both plans.

BSSP and SISC offer a 25% discount on monthly medical premiums when each spouse is enrolled as an employee and a spouse in a composite-rate plan, including the composite-rate Waiver Fee plan.

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.

OPTING OUT OF COVERAGE

Full-time employees may opt out of BSSP medical and prescription coverage, along with any associated premium charges, by providing proof of enrollment in TRICARE, Medicare, Medi-Cal or subsidized enrollment in Covered California (if allowed by the district/bargaining unit). Proof of enrollment in the alternative coverage must be provided annually during Open Enrollment to continue opting out of a BSSP medical plan.

WAIVER FEE

The Waiver Fee plan is an opt-out of medical and prescription coverage available to any full-time employee at a cost equal to the minimum plan available.

Why the Waiver Fee is NOT recommended for employees NOT double-covered within BSSP+SISC...



Enrolling in the Waiver Fee exempts both the member and any dependents from access to services at the Health and Wellness Centers as well as many of the added value benefits available through the Anthem medical plans.

Maximizing Your Benefits



TIPS FOR REDUCING YOUR OUT-OF-POCKET COSTS



Become a patient of the Health and Wellness Centers

Schedule an appointment to establish care with a primary care provider (PCP) at the Health and Wellness Centers in Chico (530-879-7438) and Oroville (530-532-5918). Building a relationship with a PCP gives you a trusted partner in managing your healthcare.

Become a Smart Medical Consumer

- Utilize only network providers
- Estimate your costs before receiving care by visiting [anthem.com/ca/sisc](https://www.anthem.com/ca/sisc).
- When you can't access the Health and Wellness Center but have an episodic or urgent medical need, try MDLIVE.
- Use Ambulatory Surgery Centers instead of outpatient hospital facilities to save on costs. See [Benefit Restrictions and Limitations](#) for more details.

Prepare for Medical Visits

Being organized helps you get the most from your provider visit. Take the following with you:

- Your medical plan ID card
- A list of your current medications
- A list of topics or questions you want to discuss with your provider

Be Medication-Savvy

- Save money on prescriptions by asking your provider about generics or generic alternatives.
- Fill your maintenance prescriptions at Costco and Costco mail order to reduce costs.
- Always follow your provider's and pharmacist's instructions when taking medications. Skipping doses or stopping medication prematurely can worsen your condition. If your medication causes side effects or makes you feel worse, contact your provider.

Stay Informed and Ask Questions

Know and understand your options before making treatment decisions -- informed patients receive better care. Use the free Teladoc Medical Expert program or seek a second opinion if you have concerns about a diagnosis or treatment plan.

Maximizing Your Benefits continued...

KNOW WHERE TO GO

Where you receive medical care can significantly impact your costs. Use this quick guide to help you decide where to go based on your condition, budget, and time.

VISIT TYPE	USE IT FOR ...
Virtual Visit (MDLive) (\$) Often available 24/7	Non-emergency health issues: <ul style="list-style-type: none">• cold, flu, allergies, headache, migraine• rashes, skin conditions• minor injuries• mental health concerns
Health & Wellness Center (\$) or Other Primary Care Office Visit (\$\$) Typically open during regular business hours	Routine medical care and management: <ul style="list-style-type: none">• preventive care• illnesses and injuries• existing conditions
Urgent Care (\$\$\$) Typically open with extended evening and weekend hours	Urgent but not life-threatening conditions: <ul style="list-style-type: none">• sprains or stitches• animal bites• high fever or respiratory infections
Emergency Room (\$\$\$\$) Open 24/7	Life-threatening conditions requiring immediate care: <ul style="list-style-type: none">• suspected heart attack or stroke• broken bones• excessive bleeding• severe pain• difficulty breathing



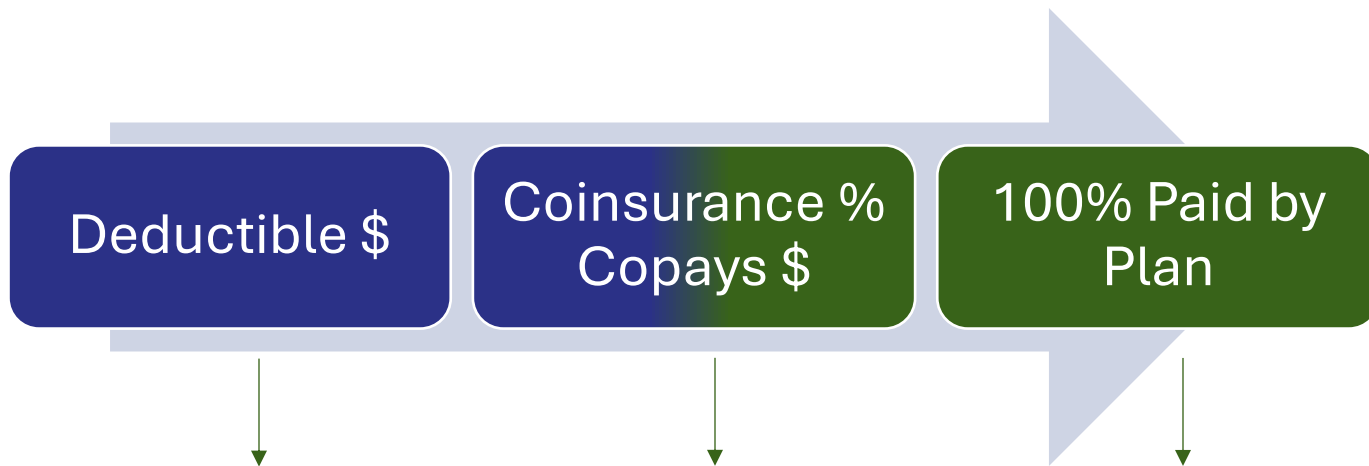
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Medical and Prescription Plans

DEDUCTIBLES, COPAYS AND OUT-OF-POCKET LIMITS

When you receive medical services under your plan, you may be responsible for paying a deductible, copayment and/or coinsurance until your out-of-pocket maximum is reached. Generally, your plan's out-of-pocket limits are based on negotiated rates for covered services performed by network providers. Some exceptions may apply.

There are three types of cost share for which you may have a responsibility to pay:



Deductible: You are responsible for paying 100% of each claim until your deductible is met for hospital-based and diagnostic services (labs, x-rays, CTs and MRIs, etc.) as well as durable medical equipment, physical therapy, chiropractic care and acupuncture. For HSA plans and the MEC 9000 plan, you also pay 100% of each claim for office visits and prescriptions until your deductible is met.

Coinsurance: Once your deductible is met, you are responsible for paying coinsurance, which is the shared cost between you and the plan.

Copayments: For non-HSA plans, the office visit charge for a doctor or mental health professional bypasses both your deductible and coinsurance. Instead, you only pay a flat dollar fee for the office visit.

Once you have paid your deductible and coinsurance/copay totals, the plan will cover 100% of claims for the remainder of the calendar year for in-network and approved services.



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



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Medical and Prescription Plans continued...

INDIVIDUAL AND FAMILY OUT-OF-POCKET MAXIMUMS

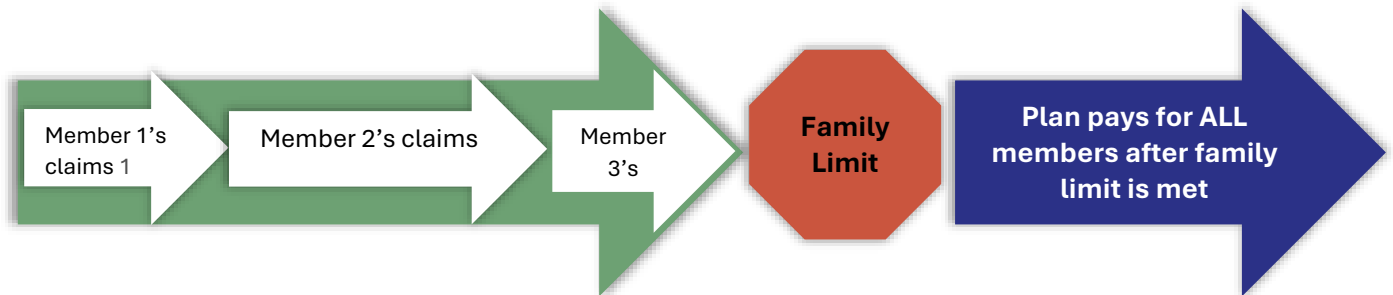
Each plan has both individual and family deductibles and out-of-pocket maximums. As family members incur claims, claims are applied to both the family's and the individual's limits. If the family limit is reached before any individual's limit is reached, the plan will pay as if everyone has reached their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



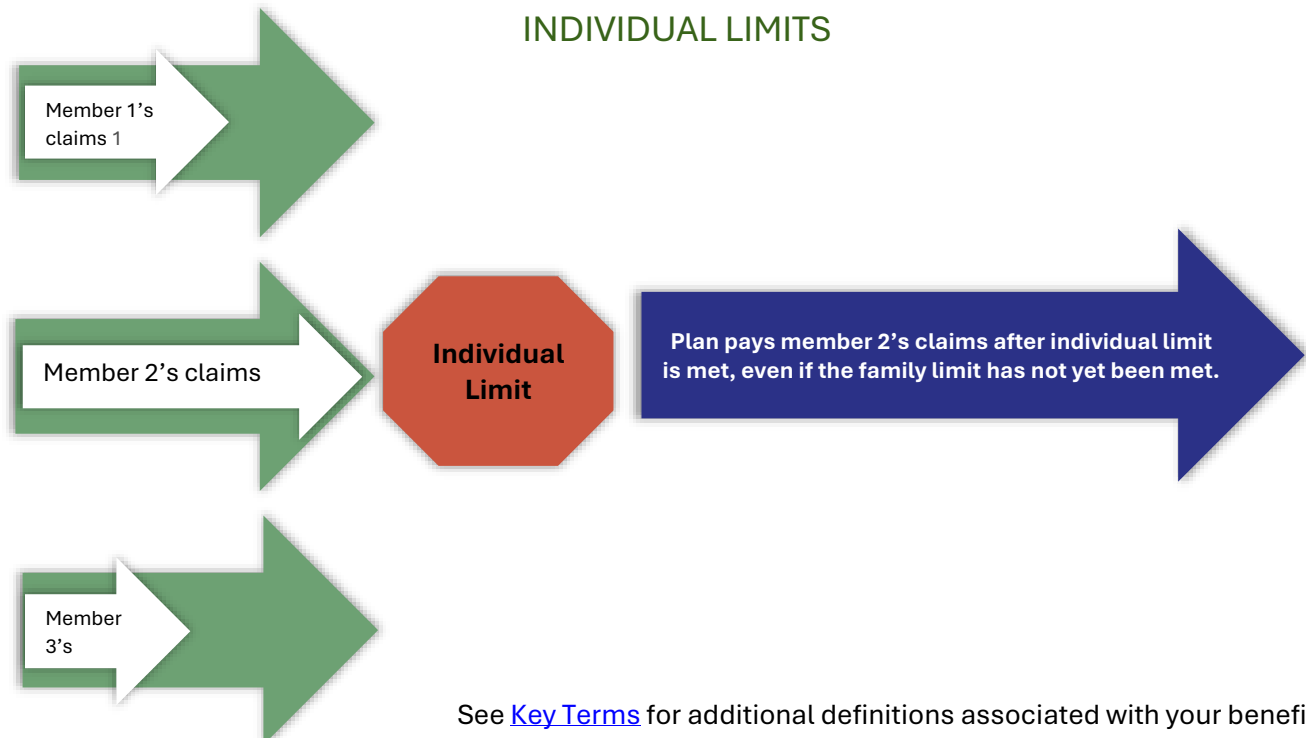
Within a plan year, you will never pay more than the individual deductible or out-of-pocket maximum for any one family member, nor will you exceed the family deductible or out-pocket limit for all family members, combined. This applies only to covered services delivered by network providers.

Non-HSA plans have separate out-of-pocket maximums for both medical and prescription claims. HSA-eligible plans and the MEC 9000 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.

Medical and Prescription Plans continued...

BENEFIT RESTRICTIONS AND LIMITATIONS



Before scheduling any surgery or procedure requiring anesthesia, contact Member Services at (800) 825-5541 to verify that your planned procedure does not have facility or anesthesia limitations.

Annual out-of-pocket limits apply to certain non-emergency surgeries, but 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 your plan’s out-of-pocket limits. *Butte County facilities are listed; call Member Services at (800) 825-5541 for other covered facilities near you.*

Value-Based Site of Care Benefit Provision

The maximum benefit amount for the 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 provision.

Arthroscopy (\$4,500 maximum benefit)	Butte County Ambulatory Surgery Centers Advanced Eye Surgery Center Ridge Eye 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 Ambulatory Surgery Center (ASC) for these procedures, you will only be responsible for the regular deductible and coinsurance amounts.
- If you use an in-network outpatient hospital facility, you will be responsible for the regular deductible and coinsurance **PLUS** any amount by which the hospital’s facility charge exceeds the maximum benefit above.

In the following cases, an exception may be granted. Consult your provider and Anthem:

- 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 Benefit Provision

When you're choosing a hospital, performance counts. Many specialty care providers in the Anthem network have earned quality awards for which they must pass a rigorous review of their processes and performance. Over and over, they've proven their expertise at delivering quality care. That could mean fewer complications, fewer readmissions, and higher survival rates.

Benefits for non-emergency surgeries listed below are restricted to facilities with the listed distinctions. Approved facilities may change throughout the year, and Butte County facilities, approved as of the date indicated, are listed below.

- Hip or Knee Replacement: Anthem Blue Distinction+ at Enloe Medical Center (2/24/2025)
- Spine Surgery: Anthem Blue Distinction+ (not approved in Butte County, updated 2/24/2025)
- Bariatric Surgery: Anthem Blue Distinction at Enloe Medical Center (2/24/2025)
- Organ and Tissue Transplant: Centers of Medical Excellence (not approved in Butte County)



Before scheduling any of the procedures listed above, contact Customer Service at (800) 825-5541 to ensure your care team and planned facility are approved as required. Customer Service can also assist in provide you with finding the nearest facility and surgeons who are a part of their program.

In rare instances, exceptions such as those listed below may apply:

- 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

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.

Other Benefit Limitations

- Non-Network Providers - The following services are not covered by the plan when obtained from a non-network provider, although exceptions apply for emergency services, lab tests and anesthesiology within a network hospital:
 - Diagnostic services (x-rays, radiology, lab work, other tests)
 - Physical Medicine (physical therapy, occupational medicine, chiropractic services)
 - Durable Medical Equipment and Medical Supplies
- Physical / Occupational / Speech Therapy and Chiropractic Care: After an initial five visits, all visits are subject to medical necessity review.
- Acupuncture: Each covered member is limited to 12 visits per year.
- 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 [anthem.com/ca/sisc](https://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 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. Other doctors and non-network providers will require payment upfront. You will complete the Blue Cross Blue Shield Global Core claim form and submit your bills for reimbursement. For updated information on international network providers, visit their website at [bcbsglobalcore.com](https://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 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.

Anthem Medical Plan Menu



NOTE: Your district/bargaining unit may not offer all plans listed below. Contact your district's HR/Payroll department for more information.

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).

	80% G \$30	80% J \$30	80% L \$30	80% M \$40	HSA \$1700 ²	HSA \$5000 ²	MEC \$9000
Active EE w/ Deps	\$2,119	\$1,925	\$1,750	\$1,573	\$1,826	\$1,305	\$1,234
Active EE 2X Discount	-\$530	-\$481	-\$438	-\$393	-\$457	-\$326	-\$309
MEDICAL							
Calendar Year Out-of-Pocket Max¹ Individual / Family	\$2,000 / \$4,000	\$3,000 / \$6,000	\$4,000 / \$8,000	\$4,000 / \$8,000	\$3,400 / \$6,800	\$6,350 / \$12,700	\$9,000 / \$18,000
Calendar Year Deductible Individual / Family	\$500 / \$1,000	\$750 / \$1,500	\$2,000 / \$4,000	\$3,000 / \$6,000	\$1,700 Single \$3,400 Ind / Fam	\$5,000 / \$10,000	\$9,000 / \$18,000
4 th Q Carryover	Yes				No		
Office Visits							
HWC	\$0				\$25		
Other Providers ³	\$30	\$30	\$30	\$40	10% after deductible	30% after deductible	0% after deductible
MDLive Virtual Visit	\$0				~ \$50 - \$75, applied to deductible		
Preventive Exam	\$0				\$0		
Diagnostic Services							
Labs	20% after deductible				10% after deductible	30% after deductible	0% after deductible
X-rays / Advanced Imaging	20% after deductible				10% after deductible	30% after deductible	0% after deductible
Therapeutic Services							
Physical or Occupational Chiropractic	20% after deductible				10% after deductible	30% after deductible	0% after deductible
Facility Services							
Emergency Room ⁴	20% after deductible + \$100				10% after deductible + \$100	30% after deductible + \$100	0% after deductible + \$100
Outpatient Surgery ⁵	20% after deductible				10% after deductible	30% after deductible	0% after deductible
Office Visit (Hospital Facility)	20% after deductible				10% after deductible	30% after deductible	0% after deductible
Hospitalization	20% after deductible				10% after deductible	30% after deductible	0% after deductible
PRESCRIPTION							
Out-of-Pocket Maximum ¹	\$2,500 / \$3,500				Combined with Medical		
Deductible (Brand, only)	\$200 / \$500				Combined with Medical		
Costco (Retail or Mail)	Up to 90-day supply: \$0 generic / \$90 brand after deductible				\$0 generic / \$90 brand after deductible		
Other Retail Pharmacy	Up to 30-day supply: \$10 generic / \$35 brand after deductible				\$9 generic / \$35 brand after deductible		
Specialty	Up to 30-day supply: \$35 after deductible				Up to 30-day supply: \$35 after deductible		

¹Plans 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.

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

³\$0 for first three primary care office visits

⁴\$100 copay waived if admitted.

⁵See Benefits Restrictions & Limitations

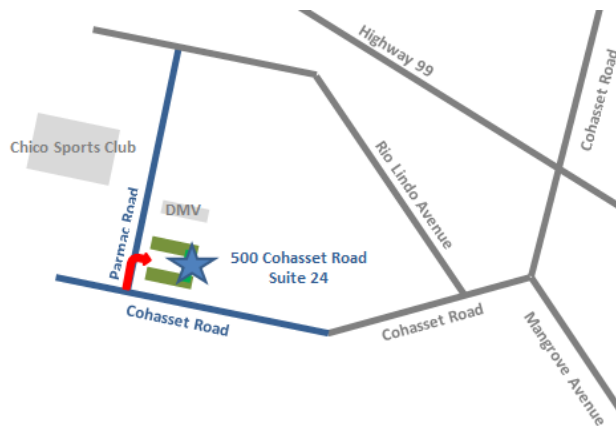
Health and Wellness Centers

BSSP’s Health and Wellness Centers, conveniently located in Chico and Oroville, offer care exclusively to those covered under a BSSP medical plan

- Convenient and extended hours
- Preventive, primary, and acute care
- Wellness services
- Fast and easy access
- Telephone appointments, when appropriate, for your maximum convenience
- Served within 10 minutes of appointment time
- Onsite lab services, including requests from outside providers (limitations may apply)
- Onsite prescription dispensary for take-home medications ... no need to stop at the pharmacy after your visit
- Non-HSA plans: all services are free, and prescriptions dispensed are \$5 or \$10
- HSA plans: Non-preventive office visits and outside labs are \$25, including prescriptions dispensed at the time of the office visit



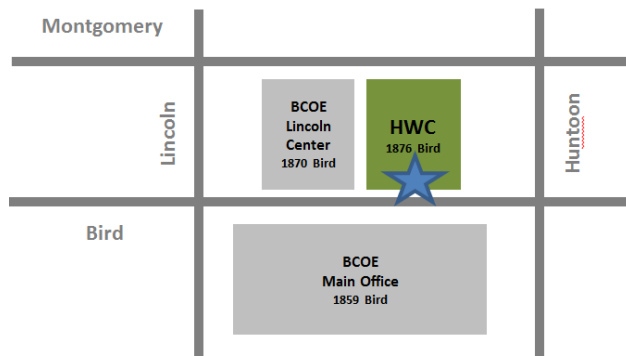
Access to the Health and Wellness Centers is limited to those enrolled in an active employee or non-Medicare retiree Anthem plan.



Chico Health and Wellness Center

Phone: 530-879-7582

Fax: 855-521-4677



Oroville Health and Wellness Center

Phone: 530-532-5918

Fax: 855-999-9239

Pharmacy Benefits

Prescription benefits for all plans are managed by Navitus. Certain medications for specific conditions are managed through Navitus' specialty pharmacy, Lumicera.



Regardless of your plan, generic medications for birth control as well as cholesterol are available at \$0 from most pharmacies, except Walgreen's.

Non-HSA plans charge a calendar-year \$200 deductible for brand-name medications as well as a monthly copayment of \$35. On HSA plans, all medications are subject to the deductible except generic birth control and cholesterol medications in accordance with IRS regulations.

COSTCO PHARMACY

You don't need a Costco membership to access special prescription savings and free Instacart prescription delivery from Costco* under all BSSP plans. And ... non-HSA plans provide free generic medications in-store and through mail order, too!

1. Generic medications (excluding narcotic pain and cough prescriptions) have a **\$0 copay** on non-HSA plans.
2. Costco will provide an option for free Instacart delivery to you via text once your prescription is filled in-store.
3. Brand name medications are also available at Costco. Once your \$200 calendar year brand name deductible is met, copayments are \$35 for a monthly supply.

You can use your 90-day prescription to start mail order service online at <https://www.costco.com/pharmacy/home-delivery>. To locate a Costco near you, call 1-800-774-2678 and press 1.

**Just tell the front-door associate that you are going to the pharmacy.*

OTHER RETAIL PHARMACIES

While 90-day mail order service is limited to Costco, pharmacy benefits are also available at most national pharmacy chains and local pharmacies, excluding Walgreen's.

30-day supply

- Deductible applies for all non-HSA plans and for brand name prescriptions on other plans.
- Non-HSA plans:
 - Generics - \$10 copay
 - Brand Name - \$200 deductible, then \$35 copay.



Added Value Medical Plan Benefits



VIRTUAL OFFICE VISITS

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 are also available via secure video. This program is available 24 hours a day, 7 days a week 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.

Services are available at \$0 effective October 1, 2025, and \$10 through September 30, 2025, on non-HSA plans. For HSA plans, services are subject to the deductible.

General Medical Conditions

- Cough
- Allergies
- Cold/flu
- Constipation
- Diarrhea/Nausea/Vomiting
- Fever
- Pink Eye
- Rashes
- Sore throats
- Urinary problems/UTI and more!

Behavioral Health

- Addictions
- Child & adolescent issues
- Depression
- Eating disorders
- Gay/Lesbian/Transgender issues
- Grief and loss
- Parenting issues
- Relationship/marital issues
- Stress
- Trauma and PTSD and more!

EXPERT MEDICAL OPINIONS

When it comes to making sure the medical treatment you get is the medical treatment you need, the Teladoc Medical Experts program is your best advocate. Teladoc will help you find comfort and clarity whenever you need to better understand the best options for your care. Teladoc 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.



Use Teladoc when you or your eligible dependents...

- Are unsure about a diagnosis or need help choosing treatment.
- Have medical questions or concerns and want a leading expert's advice.
- Need help finding a local expert who specializes in treating your condition.
- Have been admitted to the hospital and want expert guidance. 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, visit www.teladoc.com/sisc/ or call 800-835-2362.

Added Value Medical Plan Benefits continued ...

ENHANCED CANCER BENEFIT



A cancer diagnosis is scary. Lantern provides members with personalized guidance and support throughout their cancer journeys. Lantern's program elements include:

Click to play video

- Guided Support - Your personal Oncology Nurse Navigator-led team will partner with you through every step of your cancer journey.
- Accessing Excellent Care - Lantern connects you with the best in-network community oncology clinics, hospitals and National Cancer Institutes for high-quality care as close to home as possible.
- Expert Review & Advice - The Lantern team will assist in coordinating the expert review of your diagnosis and your treatment plans, recommending second opinions and referrals as needed.



The Lantern program is free to all members regardless of medical plan. The Lantern program was created to help with navigating a diagnosis and treatment, but you are not required to use the program. This program is available for eligible members who are looking for a program that provides assistance with navigating the cancer process. Prior authorization from the insurance plan is not required.

To get started, call Lantern at (855) 961-4533 to speak to a member of the Customer Care Team or visit lanterncare.com.

ON DEMAND MATERNITY AND POSTPARTUM SUPPORT



Maven offers 24/7 virtual access to one-on-one maternity and postpartum support at no cost during pregnancy and up to one year postpartum for covered employees and spouses/partners. Members are matched with a Care Advocate who connects them to trustworthy maternity and postpartum content delivered by doctors, specialists, coaches and other maternity providers. Care is specific to the issues new parents may be experiencing and include:

Pregnancy

- Midwives
- OB-GYNs
- Doulas
- Birth Planning
- Prenatal Nutritionists
- Mental Health Specialists
- Loss Support

Postpartum

- Infant Care Advice
- Pediatricians
- Lactation Counseling
- Infant Sleep Coach
- Emotional Support
- Back-to-Work Support
- Career Coaching



Members who meet the following criteria will also get a free 6-month diaper subscription!

- Enroll in the Maven program during their first or second trimester
- Have an intro call with a Care Advocate
- Have two appointments with Maven providers during pregnancy
- Complete the exit survey when their baby is born

To activate your membership, download the Maven app or visit mavenclinic.com/join/SISC.

Added Value Medical Plan Benefits continued ...

HIP, KNEE AND SPINE SURGERY BENEFIT



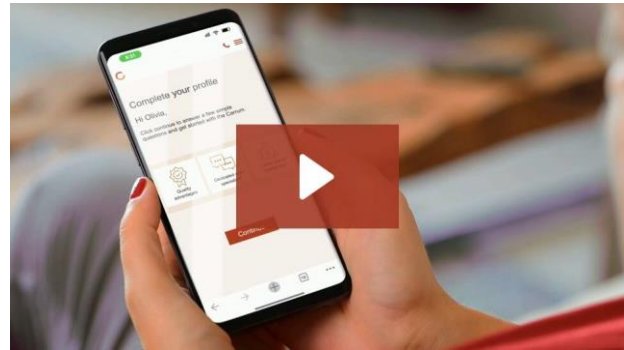
Carrum Health is an alternative surgery benefit available to you! Covered surgeries provided through Carrum are \$0 under non-HSA plans and only subject to the deductible on HSA plans. Each patient will receive personalized support and guidance from their Care Specialist.

Covered Surgeries:

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

Carrum Health services are available at the following locations:

- Adventist Health in Lodi, CA
- Stanford Valley Care in Pleasanton, California
- Community Hospital of the Monterey Peninsula (CHOMP) in Monterey, CA
- Scripps Health in San Diego, California



Click to play video

To get started, visit Carrum Health's website at info.carrumhealth.com/sisc/ or by calling 888-855-7806.

MIDI HEALTH



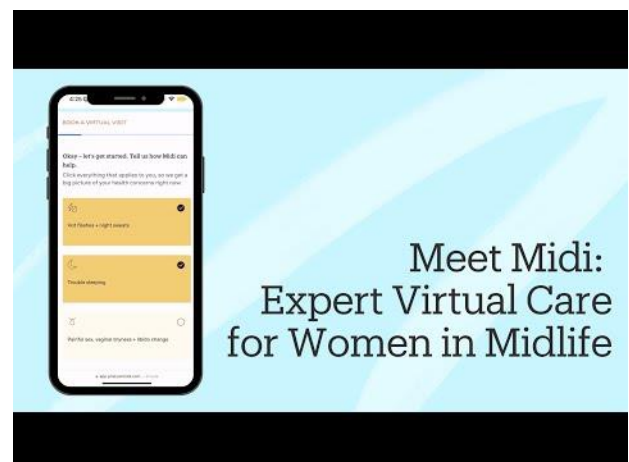
Discover real relief. Hormonal changes in midlife can bring on a host of symptoms that are often misunderstood. Midi's expert clinicians can help you find safe, effective solutions. Midi connects you to expert clinicians via virtual visits. After discussing your symptoms and health history, they help you get any necessary lab tests and create a personalized Care Plan.

Click to play video

Your regimen may include: *

- FDA-approved hormonal medications
- Non-hormonal medications
- Supplements and botanicals
- Lifestyle coaching
- Wellness therapies

Coverage for treatment options, including prescriptions, is determined by the pharmacy benefits and may vary by plan. Office visit copay applies to non-HSA plans. Services subject to deductible on HSA/MEC plans. To get started, call 888-731-8994 or go online to joinmidi.com/sisc.



Added Value Medical Plan Benefits continued ...

REMOTE EXERCISE THERAPY AND COACHING



Hinge Health is a pioneering remote exercise therapy and coaching program to help those with chronic spine, back, neck, shoulder, and knee pain, and are designed not only for the improvement of pain, but also for maintenance and prevention!

Therapy sessions can be done at home – no need to schedule PT appointments. Each piece of the program is delivered digitally, and includes:

- Personalized exercise therapy to improve strength and mobility. You'll receive tailored stretching and strengthening activities delivered through Bluetooth-connected motion sensors and a tablet, providing you with real-time feedback.
- Unlimited 1-on-1 health coaching to support you throughout the program, and keep you motivated.
- Interactive educational content every week on how to manage your specific condition, your treatment options, common misconceptions, and more.

The program is free for members enrolled in a non-HSA plan. To get started, visit hingehealth.com/sisc or call (855) 902-2777.

VIRTUAL HEALTH COACHING



Vida offers members access to a virtual care platform that treats a full range of lifestyle, chronic and behavioral conditions via a digital coaching app on your smart phone or tablet.

Members will have access to:

- 1-on-1 coaching and therapy with your own dedicated Vida representative.
- Trackers and devices to monitor progress, and tools and resources to support living a healthy lifestyle.
- Vida therapists who can assist with mild to moderate anxiety and depression.

Vida health coaches who can assist with chronic conditions, such as asthma, high blood pressure, and diabetes, or lifestyle and behavior changes, such as losing weight, exercising more, and eating better.

Visit www.vida.com/sisc to get started. All Vida programs are free for non-HSA plan members.

CENTIVO CARE

As part of your Anthem medical benefits, you have 24/7 access to a Care Team who works together to offer you primary care, mental health support through one app. Centivo providers diagnose conditions, manage prescriptions, refer to specialists, answer follow-up questions using video visits or live chat.



Centivo Care is available at no cost to members on a non-HSA plan. Download the Centivo Care app to register for your membership.

Dental



Regular visits to your dentist protect more than your smile; they 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.

NOTE: Your district/bargaining unit may not offer all plans listed below. Contact your district’s HR/Payroll department for more information.

	Plan 1	Plan 8	Plan 10	Plan 12
Monthly Rate	\$69	\$115	\$124	\$145
Network	PPO Only	PPO + Premier		
Calendar Year Plan Maximum	\$1,200/individual PPO \$1,000/individual non-network <i>Diagnostic and Preventive Services do not count toward the Calendar Year Plan Maximum</i>	\$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		
Cleanings	3 per calendar year			
Diagnostic & Preventive	Plan pays 100%	Plan pays 70% - 100%		
Basic Services Fillings Root Canals Periodontics	Plan pays 80%	Plan pays 70%-100%		
Major Services	Plan pays 50%	Plan pays 70%-100% (prosthodontics are 50%)		
Orthodontic Services	Not covered		Plan pays 100% Up to \$2,000 lifetime	Plan pays 100% Up to \$2,500 lifetime
Occlusal Night Guard	Plan pays 50% up to \$750 lifetime			

Added Value Dental Plan Benefits



QUIP



Quip (formerly Toothpic) is a photo-based smart-device app when you're looking for a quick exam. It provides diagnostic screenings with a Delta Dental dentist for **non-urgent dental assessments** within 24 hours. Quip is an ideal solution for:

- Consult or second opinion
- Members who prefer privacy and feel more comfortable off video
- Members in remote areas with bandwidth constraints
- Busy members – no need to schedule an appointment

To register, visit deltadental.getquip.com and click the Register Now button.

VIRTUAL CONSULT



Virtual Consult

Virtual Consult provides real-time diagnostic urgent care with an in-network Delta Dental dentist for problem-focused issues over video. Virtual Consult is an ideal solution for:

- Members with urgent dental needs
- Members who prefer more face-to-face interactions
- Members in remote areas with no providers close by
- Busy members – schedule an appointment that works with your schedule to be seen live by a dentist

To get started, visit <https://www1.deltadentalins.com/members/virtual-dentistry.html>. For the best results, please use Chrome as your browser and close any VPN or firewall connections before your appointments.

LIFEPERKS DISCOUNT PROGRAM



Save on products and services that help you live a healthy, balanced lifestyle. As a Delta Dental member, you can sign up for LifePerks and get unlimited access to discounts on oral care, fitness, groceries, and meal delivery, as well as travel, entertainment, pet insurance, childcare and more.

LifePerks Special Offers

Oral Health	Discounts to help keep your oral health on track
Health & Wellness	Access whole body health deals on nutrition, fitness equipment and gym memberships
Lifestyle	Save big on groceries, home services, financial and auto services
Travel & Entertainment	Keep the whole family entertained with discounted access to movie theaters, theme parks, vacation planning and travel services

To register and start saving, visit LifePerksML.lifemart.com.

For more information on Delta Dental's member perks, visit deltadentalins.com/memberperks.

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.

NOTE: Your district/bargaining unit may not offer all plans listed below. Contact your District HR/Payroll department for more information.

	Plan 4	Plan 4X	Plan 8	Plan 8X
Monthly Rate	\$19	\$32	\$29	\$42
Examination Benefit	\$10 copay then plan pays 100%			
Frequency (last service date)	1 x every 12 months			
Materials	\$10 copay then plan pays 100%			
Eyeglass Lenses	Basic lens combined with exam			
Single Vision				
Bifocal				
Trifocal				
Enhancements				
Tints/Light-reactive lenses/UV protection/Standard progressive lenses	\$0			
Premium and Custom progressive lenses	\$40			
Anti-glare coating	\$40			
Frequency (last service date)	1 x every 12 months			
Frames Benefit	\$270 featured frame brands allowance \$250 frame allowance 20% savings on the amount over your allowance \$135 Costco®/Walmart®/Sam's Club® frame allowance			
LIGHTCARE™	\$250 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts			
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	\$250 allowance (copay waived; instead of eyeglasses)	\$50 copay for fitting exam and annual supply of contacts	\$250 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
Kids Care Benefit Children 17 and under	Eligible for two covered exams, if needed, every 12-months. Additional lenses with a minimum prescription change, and frames every 12 months (plans 4 and 4x) are included.			
Computer Vision Care	Expanded exam to detect eye health issues related to extensive use of computers and digital devices, plus a \$130 retail frame allowance on eyewear specifically designed to reduce eyestrain and fatigue from daily use of devices.			

Added Value Vision Plan Benefits



EXTRA SAVINGS

Glasses and Sunglasses

- Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details.
- 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last exam.

Routine Retinal Screening

- No more than a \$39 copay on routine retinal screening as an enhancement to an exam.

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

ONLINE EYEWEAR RETAILER

Eyeconic® seamlessly connects your eyewear, your insurance coverage, and the VSP® doctor network. Plus, you get the convenience of online shopping along with the personal touch from a VSP doctor.



Online shoppers will love:

- A huge selection of contact lenses and designer frames 24/7—and the Virtual Try-On tool.
- Free frame adjustment or contact lens consultation.
- Verification of your prescriptions and the 25-point inspection process to ensure your eyewear is just right.

IT'S EASY TO USE YOUR VSP BENEFIT

1. Create an account at vsp.com. Review your vision benefit and access your eligibility and coverage information, including how to apply your benefits at Eyeconic.
2. Find superior eye care near you. The decision is yours—choose a conveniently located VSP doctor or any out-of-network provider. Visit vsp.com or call 800-877-7195 to find the best provider for you.
3. Check out [Eyeconic.com](https://eyeconic.com) and browse the frame brands you love. You can connect to your VSP benefits, upload your prescription, and order your glasses following your exam.

TRUHEARING® HEARING AID DISCOUNT PROGRAM



VSP members can save up to 60% on the latest brand-name hearing aids. Dependents and even extended family members are eligible for exclusive savings, too. TruHearing provides members with:

- Three provider visits for fitting and adjustments
- A 45-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid on all non-rechargeable aids
- A comprehensive hearing exam from a crCentivotialed TruHearing provider, who will recommend hearing aids that accommodate your hearing loss, budget and lifestyle.

Call a TruHearing Hearing Consultant at 1-877-372-4040 who can answer your questions, verify your insurance coverage and set up an exam with a provider near you. Check out truhearing.com/vsp for more information.

Mental Health Support Services



EMPLOYEE ASSISTANCE PROGRAM

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through Anthem EAP 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 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 hours a day, 7 days a week 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 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).

You'll be provided with 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. EAP will schedule an appointment on your behalf upon request.

If you prefer another therapist after the first meeting, call the toll-free number back and EAP will provide you with another list of EAP counselors.

EAP Legal Support

The EAP network of legal professionals can discuss almost any type of legal issue with you during a 30-minute consultation including:

- Personal business legal services
- Civil/consumer issues
- Estate planning law
- IRS matters
- Personal injury
- Personal/family legal services
- Real estate

Additional legal services beyond the initial consultation are available at a discount. EAP can also provide a list of community resources that may be available at reduced cost or no cost.

Mental Health Support Services continued...

EAP Financial Services

EAP provides a free telephone consultation with a financial professional who can help you:



- Understand your financial situations
- Develop a new frame of mind for thinking about money
- Come up with ideas to help get ahead
- Stay on track

If you need help beyond the initial consultation, EAP can identify financial professionals who offer additional services. EAP can also provide a list of community resources that may be available at reduced cost or no cost.

EAP Work-Life Resources

Online Search – Locate child and elder care providers by completing the online search questionnaire on the EAP website.

Tobacco-Free Resources – The EAP website offers a variety of tools to help kick the habit, including articles, podcasts, and links to other sources of support.

Webinars – EAP offers a variety of health and wellness webinars on our website, including Creating a Personal Development Plan; Riding the Waves of Change; Raising Well-adjusted Kids; and more.

Savings Center – The Savings Center is a discount shopping program that is provided through the Perks At Work website. It offers discounts of up to 25% on name brand, practical, and luxury items.

TALK SPACE



Talkspace brings you convenient, personal, and professional online individual and couples' therapy.

WHO IS ELIGIBLE?

All employees of a BSSP district and their household members.

WHAT IS AVAILABLE?

- Regularly send text, audio, and video messages to a dedicated licensed therapist anytime, anywhere for ages 13+.
- Live sessions via chat, audio and video are also available.
- 6 1-hour confidential counseling sessions per incident, per person, per year with licensed professionals at no cost.

HOW TO GET STARTED...

- Visit anthemeap.com, click EAP Member Login, enter Company Name: SISC
- Click the Get Started button in the Find a Counselor section to be directed to the "Talkspace" option.
- Click the "Visit Portal" link to be taken to the Talkspace registration page.
- Enter the letters "EAP", a space, and your company code, SISC, in the "Organization Name" field to access services.

Mental Health Support Services continued...

LEARN TO LIVE



The free Learn to Live program is built on the proven principles of Cognitive Behavioral Therapy (CBT). Digital tools are available anywhere, anytime to help you identify thoughts and behavior patterns that affect your emotional well-being – and work through them.

- **Personalized, one-on-one coaching:** Members team up with an experienced coach who can provide support and encouragement by email, text, or phone.
- **Build a support team:** Members can add friends or family members as “teammates”. They can help each other stay motivated and accountable while working through programs.
- **Practice mindfulness on the go:** Members receive weekly text messages filled with positivity, quick tips, and exercises to improve your mood.
- **Live and on-demand webinars:** Members learn how to improve mental well-being with useful tips and advice from experts.

Who Is Eligible?

All employees of a BSSP district and their household members

How to Get Started...

- Visit anthemeap.com, click EAP Member Login, enter Company Name: SISC
- Scroll down to Self-Paced Courses and Resources.
- Click the arrow next to Emotional Well-being Resources to be directed to the “Learn to Live” registration page.

Voluntary Benefits



TRUSTMARK UNIVERSAL LIFE WITH LONG TERM CARE (LTC)

[Click to play video](#)

What is Universal Life Insurance with Long Term Care?

Universal Life Insurance with Long Term Care through Trustmark provides lifelong protection with flexible premiums. *It is one policy with two benefits - life insurance coverage for your family and long-term care benefits if you need them.*



Program Highlights

- Coverage is available for yourself, your spouse, and your child(ren)
- Flexible permanent insurance designed to last a lifetime
- Benefits for long-term care services such as home health or nursing home care - you can access 4% of the selected life benefit per month up to 25 months if you need LTC
- If you collect a benefit for LTC, your full death benefit is still available for your beneficiaries, as much as doubling your benefit
- You have two options: Universal Life with LTC and Universal Life Events with LTC. The difference between the two is a reduced death benefit amount at age 70 on Universal Life Events with LTC - *your long-term care benefit amount will not decrease with age.*
- The plan includes a Terminal Illness Benefit Rider which accelerates 75% of the death benefit amount when life expectancy is 24 months or less.
- You pay for this benefit conveniently through payroll deduction.
- The plan is portable, meaning you can take this with you, at the same rate, if you change jobs or retire.

Why is Long Term Care Coverage Important?

Long Term Care coverage provides peace of mind knowing you won't become a burden to loved ones if you become ill. While it's true that Medicare may cover some long-term care costs, Medicare's coverage can be very limited. Long Term Care coverage is the best way to protect yourself, your family, and your financial assets.

- Seniors ages 65 and over have a nearly 70% chance of needing Long Term Care services in their future¹
- Women (3.7 years) stay in long term care facilities longer than men (2.2 years)¹
- 20% of today's 65-yearolds will need long term care for longer than 5 years¹

Why Act Now?

- Premiums are based on age - the younger you are when you enroll, the more benefit you receive for the same premium.
- California has introduced legislation for a mandatory, state-run LTC insurance for workers in California. Everyone employed in California would pay a premium based on wages. *Workers with individual LTC insurance may be exempt from participating in this state-run program.*

Voluntary Benefits continued...



PETS BEST PET INSURANCE

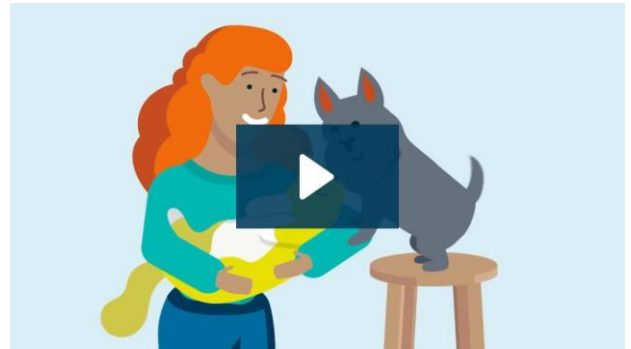
Pets Best voluntary pet insurance helps provide peace of mind to pet parents by reimbursing you for your pet’s eligible veterinary bills. Get flexible accident, illness, and routine care coverage customized to your pet and your budget.

Pets Best is available to all active employees and retirees participating in BSSP’s medical, dental and/or vision insurance programs.

Click to play video

Pets Best plans offer:

- Fast claims processing and payment
- Optional direct deposit and direct vet pay options
- Use any veterinarian in the U.S. - including specialty and emergency clinics
- Exclusive employee discount on a BestBenefit plan
- Optional coverage for routine care
- Access to a 24/7 pet helpline powered by whiskerDocs



Available Plan Options:

- **Accident Only Plan** - Designed for those on a limited budget who want great coverage for accidents like broken legs, snake bites, foreign body ingestion and more.
- **BestBenefit Plan** – You choose the level of coverage, the amount of annual deductible (in \$50 increments) and the percentage of reimbursement.

BestBenefit Plan Coverage	ESSENTIAL	PLUS	ELITE
Annual Coverage Limit for Unexpected Accidents and Illnesses	\$5,000 - Unlimited	\$5,000 - Unlimited	\$5,000 - Unlimited
Annual Deductible Options	\$50 - \$1,000	\$50 - \$1,000	\$50 - \$1,000
Reimbursement Percentage Options	70% - 90%	70% - 90%	70% - 90%
Accidents, Illnesses, Cancer, Hereditary Conditions, Emergency Surgeries & Rx Meds	✓	✓	✓
Accident & Illness Exam Fees associated with the diagnosis of your pet for an eligible injury or illness. This is not intended to cover routine exams.		✓	✓
Rehabilitative, Acupuncture & Chiropractic Coverage to treat eligible injuries and illnesses.			✓

- **Optional Routine Care** - Coverage to help pay for regular and expected veterinary visits. *Wellness Plans are available with the purchase of a BestBenefit plan, only.*

Premiums are based on the animal’s age, breed, location and plan selection. From the policy start date there will be just one waiting period of 6 months for cruciate ligament events. Once met, the waiting period is waived for continuous, uninterrupted policy renewals. Coverage excludes pre-existing conditions (18 month look-back period).

To begin, enroll at www.petsbest.com/BSSPPETS or call 888-984-8700 and reference code BSSPPETS.

Voluntary Benefits continued

MASA AMBULANCE COST REIMBURSEMENT



The Medical Air Services Association (MASA) voluntary ambulance benefit pays your out-of-pocket deductible, copayment or coinsurance responsibility for any emergency ground or air medical transport.

- Coverage ANYWHERE in all 50 states and Canada whether at home or away
- Coverage for BOTH emergent ground ambulance and air ambulance transport REGARDLESS of the provider
- Non-emergent transport services between medical facilities if a higher level of care is needed at another facility
- Coverage for repatriation/recuperation via ground or air medical transportation to another facility in the event a member is hospitalized more than 100 miles from their home.
- Benefits are not payable for transportation related to the following:
 - elective and/or cosmetic surgery
 - occurrences related to military personnel during active-duty hours
 - treatment for mental illness or disease
 - terminal conditions and/or illnesses
- Claims must be submitted within 180 days

The MASA Emergent Plus benefit is available, at a cost of \$14/month, to all active employees and non-Medicare retirees participating in BSSP's medical, dental, vision and/or life insurance programs.



Click to play video

Available to these employers:

- | | | | |
|---------|------------|----------------|---------------|
| BCOE | BSSP | Biggs USD | Chico USD |
| CCDS | Durham USD | Golden Feather | Gridley USD |
| Inspire | Manzanita | OCESD | Pioneer Union |

FLEXIBLE SPENDING ACCOUNTS

Healthcare FSA

Healthcare FSAs allow you to set aside money tax-free for eligible medical costs, such as doctor visits, prescription drugs, prescription contact lenses, and dental procedures. Additionally, your entire election amount is available to you at the beginning of the plan year.

Healthcare FSAs operate under a “use or lose” system. That means you’ll want to use all of your funds prior to the next plan year, or you will lose whatever amount is left. This plan does include the Carryover Provision which allows you to carry over up to \$500 of unused contributions from one plan year to the next.

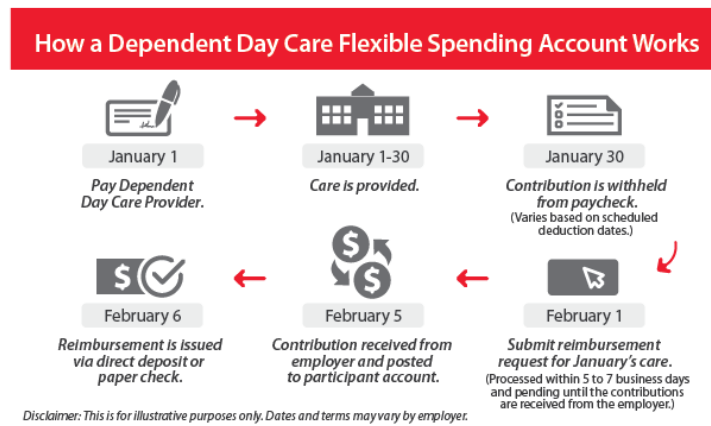


[Click to play video](#)

Dependent Care Account

A Dependent Care Account is used to reimburse yourself for eligible dependent day care expenses, such as after-school care, summer day camp, and day care. Your contribution is withheld from your paycheck before tax, which in turn reduces your overall tax burden.

Like Healthcare FSAs, Dependent Care Accounts operate under a “use or lose” system. That means you’ll want to use all of your funds prior to the next plan year, or you will lose whatever amount is left.



American Fidelity Voluntary Benefits

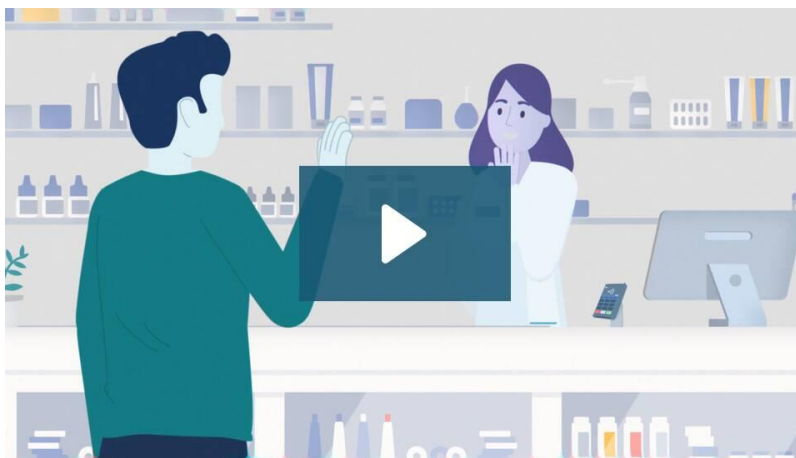
HEALTH SAVINGS ACCOUNT

A Health Savings Account (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-eligible medical 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 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.
- 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.

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

- You must be enrolled in an HSA-eligible medical 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 Healthcare Flexible Spending Account (FSA). However, having a Limited Purpose FSA is permitted for use in paying for dental and vision expenses, only.



Click to play video

American Fidelity Voluntary Benefits

DISABILITY INCOME INSURANCE

Disability income Insurance is designed to help protect your finances in case of a covered injury or illness. It provides a benefit to help cover costs while you are unable to work by paying some of your gross monthly earnings. You will have the opportunity to apply for coverage without answering medical questions (pre-existing conditions may apply). You can select a benefit amount and elimination period that meets your financial needs. Benefit payments are made directly to you to use the funds where you need them.



Click to play video

CRITICAL ILLNESS INSURANCE

Limited Benefit Critical Illness pays benefit upon diagnosis of certain covered life-altering illnesses and helps with costs not covered by medical insurance. Various coverage options are available to choose from. Coverage also includes a screening benefit that pays you when you receive your annual health screenings, including stress test, echo cardiograms and more.



Click to play video

American Fidelity Voluntary Benefits

CANCER INSURANCE

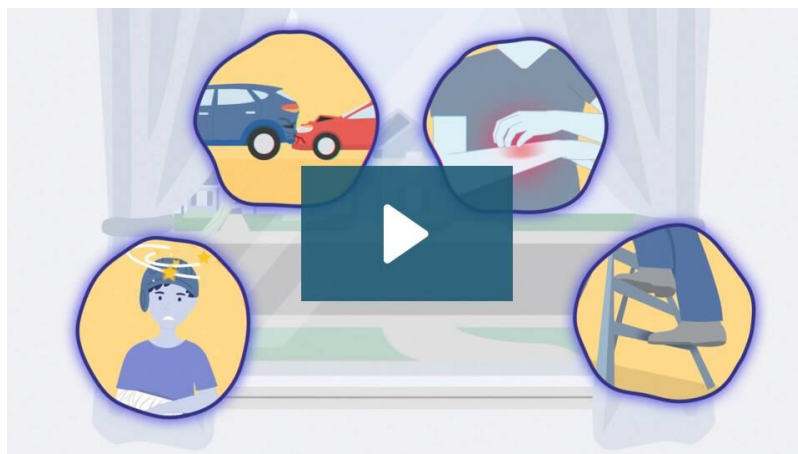
Limited Benefit Individual Cancer Insurance may help ease the financial burden of cancer treatment, including non-medical expenses like travel and lodging, so you can focus on recovery. Benefit payments are made directly to you. You can enroll yourself or extend coverage to your family. Coverage also includes a screening benefit that pays you when you receive your annual internal cancer screening tests, including Mammograms, PAPs and Colonoscopies.



Click to play video

ACCIDENT ONLY INSURANCE

Prepare for the unexpected with Limited Benefit Accident Only Insurance. Accident Only Insurance may help manage out-of-pocket costs to treat injuries resulting from a covered accident and provides benefit payments directly to you.

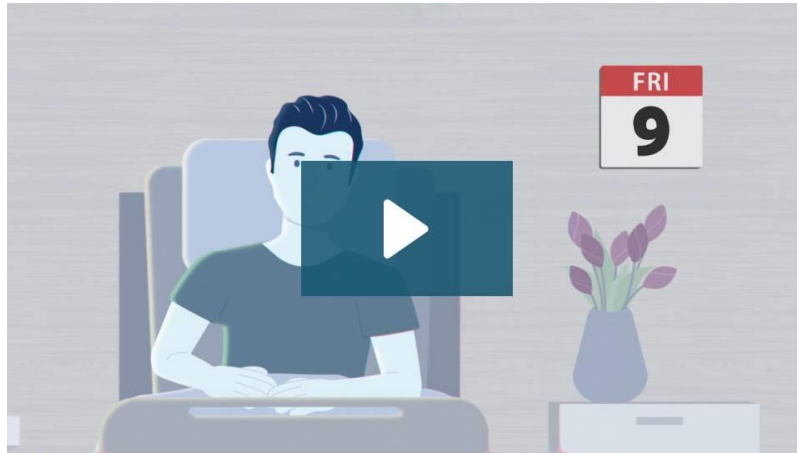


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American Fidelity Voluntary Benefits

HOSPITAL INDEMNITY INSURANCE

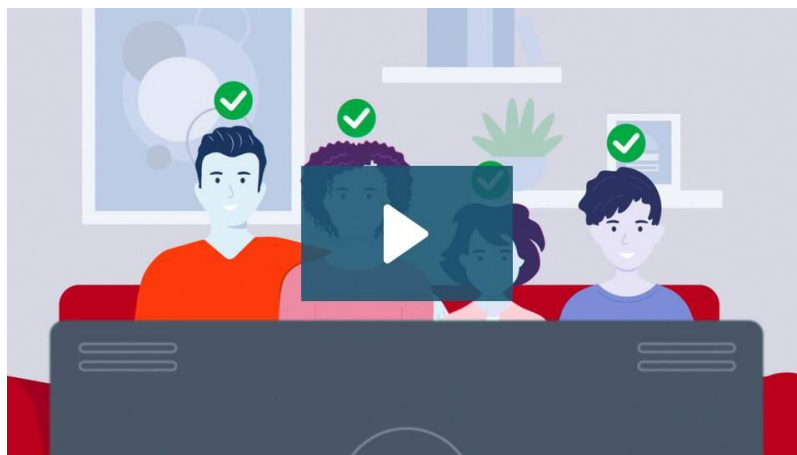
Limited Benefit Hospital Indemnity Insurance helps pay for out-of-pocket costs, like a hospital stays. Major medical insurance plans are designed to pay a large portion of your medical costs. But with a high-deductible health plan, you must pay out of your own pocket until you meet your deductible and plan maximum.



Click to play video

LIFE INSURANCE

Life Insurance may help ensure your family is financially protected in the event of a loss. You own the policy, so you can take it with you to a different job or into retirement.



Click to play video

For Assistance

Benefit	Provider	Phone Number	Website
Eligibility	Butte Schools Self-Funded Programs	530-879-7438 bssp@bsspjpa.org	bsspjpa.org
Health and Wellness Centers		530-879-7582 C 530-532-5918 O	bsspjpa.org/health-and-wellness-center
Medical PPO	Anthem	(800) 825-5541	anthem.com/ca/sisc
Rx Administrator	Navitus (Anthem)	866-333-2757	memberportal.navitus.com/
Mail Order	Costco Mail Order	800-607-6861	costco.com/home-delivery
Medical HMO	Kaiser	800-464-4000	kp.org
Dental	Delta Dental	800-765-6003	deltadentalins.com
Vision	VSP	800-877-7195	vsp.com
Life	The Hartford	888-563-1124	
EAP	Anthem EAP	800-999-7222	anthemeap.com
Virtual Primary Care	Centivo Care		App via iOS and Android
Virtual Office Visit	MDLIVE	800-657-6169	mdlive.com/sisc
Virtual Menopause Care	Midi Health	888-731-8994	joinmidi.com/sisc
Digital Health Coaching	Vida		vida.com/sisc
Remote Exercise Therapy	Hinge Health	855-902-2777	hingehealth.com/sisc
Expert Medical Opinion	Teladoc Medical Experts	855-380-7828	teladoc.com/sisc
Surgery Benefit	Carrum Health	888-855-7806	info.carrumhealth.com/sisc/
On Demand Maternity Program	Maven		mavenclinic.com/join/SISC
Cancer Benefit	Lantern	855-961-4533	lanterncare.com
Long Term Care	Trustmark	800-918-8877 (Policy) 877-201-9373 (Claims)	TrustmarkVB.com trustmarkVB.com/claims
Pet Insurance	Pets Best	888-984-8700	www.petsbest.com/BSSPPETS
Ambulance Cost Reimbursement	MASA	800-643-9023	masamts.com
Voluntary Benefits	American Fidelity	800-662-1113	americanfidelity.com/bssp

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 in individual deductibles in a year. **IMPORTANT:** Individuals in a family

only must 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.