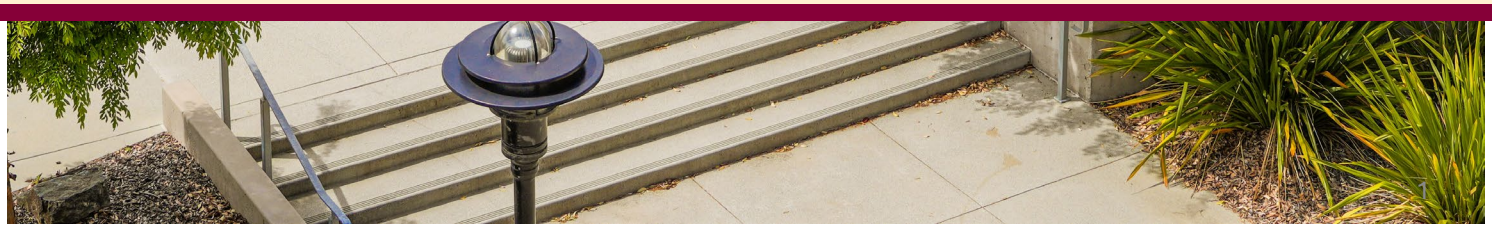
2026

HARTNELL COLLEGE

Employee Benefits Overview

Your Benefits. Your Choice.



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MEDICARE PART D NOTICE

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

Welcome to Your Benefits Guide

The benefits in this summary are effective **January 1, 2026.**

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

This guide provides an overview of your healthcare coverage, life, disability, and more.

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

IMPORTANT NOTE: This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail.

Who is Eligible?

You are eligible if you are a full-time employee working 30 or more hours per week.

The following dependents are eligible for benefits:

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit. Review the Affidavit carefully because it will include important information regarding the guidelines for adding, ending or changing your domestic partner.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

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

- Parents, grandparents, and siblings.
- Employees who work less than 30 hours per week, temporary employees not on Hartnell College's payroll, contract employees, or employees residing outside the United States.

When you can enroll

New Hire Enrollment	New hire coverage begins on the first of the month following your date of hire. You must enroll within 30 days of becoming eligible.
Open Enrollment	The one time each year that you can make changes to your benefits for any reason. Open enrollment is generally held in October every year for a January 1st effective date.
Qualifying Life Event	A qualifying life event is a significant change in your life that allows you to make changes to your benefits outside of open enrollment. See the next page for more information.

Changing Your Benefits

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

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

Any change you make must be consistent with the change in status. All proper documentation is required to cover dependents (marriage certificates, birth certificates, tax forms etc.).

You must submit your change to your HR Benefits person within 30 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Prior year's Tax forms showing the couple as married
    - Exception to the Tax Form: A marriage certificate will be accepted for newly married couples when filing has not yet been required for the current tax year.
- Domestic Partners Affidavit
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until the next open enrollment period.

Eligibility Documentation Checklist

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

Dependent Type	Required Documentation
Spouse	▪ Prior year's Federal Tax Form that shows the couple was married (First page only, financial information may be blocked out). (Exception to the Tax Form: A marriage certificate will be accepted for newly married couples when filing has not yet been required for the current tax year.)
Domestic Partner	▪ A Certificate of Registered Domestic Partnership issued by the State of California or a certified copy of the Declaration of Domestic Partnership that includes the dated, signed Secretary of State Certification Stamp. (Enrolling a Domestic Partner may cause the employer contribution to become taxable.)
Children, Stepchildren, and/or Adopted Children up to age 26	▪ Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) ▪ Legal Adoption Documentation
Legal Guardianship up to age 18	▪ Legal U.S. Court Documentation establishing Guardianship
Unmarried Disabled Dependents over age 26 (requires enrollment in a SISC medical plan)	**BLUE SHIELD (All items listed below are required)** ▪ Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) ▪ Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (First page only, income information may be blocked out) ▪ Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage. ▪ Completed Declaration of Disability for Overage Dependent Child **KAISER (All items listed below are required)** ▪ Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) ▪ Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (First page only, income information may be blocked out) ▪ Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage.
Retirees and/or Dependents on a Retiree Plan Age 65 or Over	▪ Proof of enrollment in Medicare Part A & Part B (copy of current Medicare card or Medicare enrollment confirmation letter showing effective dates of Part A and Part B)

Medical

Our medical plans offer comprehensive coverage. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose.

Medical Plan Overview

This guide serves as a summary of the medical plans. Please review the plan documents before selecting a plan.

	What you need to know
Blue Shield PPO *Blue Shield Network*	• Must meet deductible for some services before the plan begins to pay a % of the cost • Out-of-network coverage; higher costs
Kaiser HMO *Kaiser Network*	• Access to Kaiser providers/facilities exclusively • Requires PCP to see specialist • No deductible • Predictable costs

Medical Plans

This table shows member cost share.

	SISC Blue Shield PPO 80K		SISC Blue Shield PPO 80M (HRA)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible[1] Individual Coverage Family Coverage	$1,000 per individual $2,000 per family	$1,000 per individual $2,000 per family	$3,000 per individual $6,000 per family	$3,000 per individual $6,000 per family
Calendar Year Out-of-Pocket Maximum[2,3] Individual Coverage Family Coverage	$3,000 per individual $6,000 per family	Unlimited	$4,000 per individual $8,000 per family	Unlimited
HRA Employer Contribution	Not Applicable		$200 per month	
Office Visit Primary Care/Specialist	$30 copay (First 3 PCP visits are $0 copay)	50% after deductible	$40 copay (First 3 PCP visits are $0 copay)	50% after deductible
Preventive Services	No charge	Not covered	No charge	Not covered
Urgent Care	$30 copay	50% after deductible	$40 copay	50% after deductible
Emergency Room	$100 copay + 20% (copay waived if admitted)		$100 copay + 20% (copay waived if admitted)	
Lab and Imaging Basic/Complex	20% after deductible	Not covered	20% after deductible	Not covered
Outpatient Surgery/Services	20% after deductible	All charges above $350	20% after deductible	All charges above $350
Inpatient Hospitalization	20% after deductible	All charges above $600	20% after deductible	All charges above $600
Chiropractic (up to 20 visits/year)	20% after deductible	Not covered	20% after deductible	Not covered
PRESCRIPTION DRUGS – NAVITUS HEALTH SOLUTIONS				
Calendar Year Deductible	None		$200 per individual $500 per family (Only applies to Brand and Specialty RX)	
Calendar Year Out-of-Pocket Maximum	$1,500 per individual $2,500 per family		$2,500 per individual $3,500 per family	
Retail- 30 Day Supply **Network Generic** **Network Brand** **Costco Generic** **Costco Brand**	 $7 copay $25 copay $0 copay $25 copay		 $10 copay $35 copay $0 copay $35 copay	
Mail Order- 90 Day Supply **Network Generic** **Network Brand**	 $0 copay $60 copay		 $0 copay $90 copay	

[1]This family deductible is embedded, meaning that the plan begins to make payments for a member once they reach their individual deductible.
[2]This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum.
[3]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

Medical Plan

This table shows member cost share.

	SISC Blue Shield HSA $5,000 (HSA)	
	In-Network	**Out-of-Network**
Calendar Year Deductible[1] Individual Coverage Family Coverage	$5,000 per individual $10,000 per individual/$ per family	$5,000 per individual $10,000 per individual/$ per family
Calendar Year Out-of-Pocket Maximum[2,3] Individual Coverage Family Coverage	$6,350 per individual $12,700 per individual/$ per family	Unlimited
HSA Employer Contribution	$350 per month	
Office Visit Primary Care/Specialist	30% after deductible	50% after deductible
Preventive Services	No charge	Not covered
Urgent Care	30% after deductible	50% after deductible
Emergency Room	$100 copay + 30% (copay waived if admitted)	
Lab and X-ray Basic/Complex	30% after deductible	Not covered
Outpatient Surgery/Services	30% after deductible	All charges above $350
Inpatient Hospitalization	30% after deductible	All charges above $600
Chiropractic (up to 20 visits/year)	30% after deductible	Not covered
Acupuncture (up to 12 visits/year)	30% after deductible	50% after deductible
PRESCRIPTION DRUGS - NAVITUS HEALTH SOLUTIONS		
Calendar Year Deductible	Combined with medical	
Calendar Year Out-of-Pocket Maximum	Combined with medical	
Retail- 30 Day Supply **Network Generic** **Network Brand** **Costco Generic** **Costco Brand**	 $9 copay $35 copay $0 copay $35 copay	
Mail Order- 90 Day Supply **Network Generic** **Network Brand**	 $0 copay $90 copay	

[1]This family deductible is embedded, meaning that the plan begins to make payments for a member once they reach their individual deductible.
[2]This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum.
[3]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

Medical Plan

This table shows member cost share.

	SISC Kaiser HMO $10 (HRA)
	In-Network Only
Calendar Year Deductible Individual Coverage Family Coverage	None
Calendar Year Out-of-Pocket Maximum[1,2] Individual Coverage Family Coverage	$1,500 per individual $3,000 per family
HRA Employer Contribution	$200 per month
Office Visit Primary Care Specialist	$10 copay $10 copay
Preventive Services	No Charge
Urgent Care	$10
Emergency Room	$100
Lab and Imaging Basic/Complex	No Charge
Outpatient Surgery/Services	$10
Inpatient Hospitalization	No Charge
Chiropractic (up to 30 visits/year)	$10
PRESCRIPTION DRUGS – KAISER PERMANENTE	
Plan Year Deductible	None
Plan Year Out-of-Pocket Maximum	Combined with medical
Retail- 30 Day Supply Generic Brand Name Specialty	$10 copay $10 copay $10 Copay
Mail Order- 90 Day Supply Generic Brand Name Specialty	$10 copay $10 copay $10 Copay

[1]This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum.
[2]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

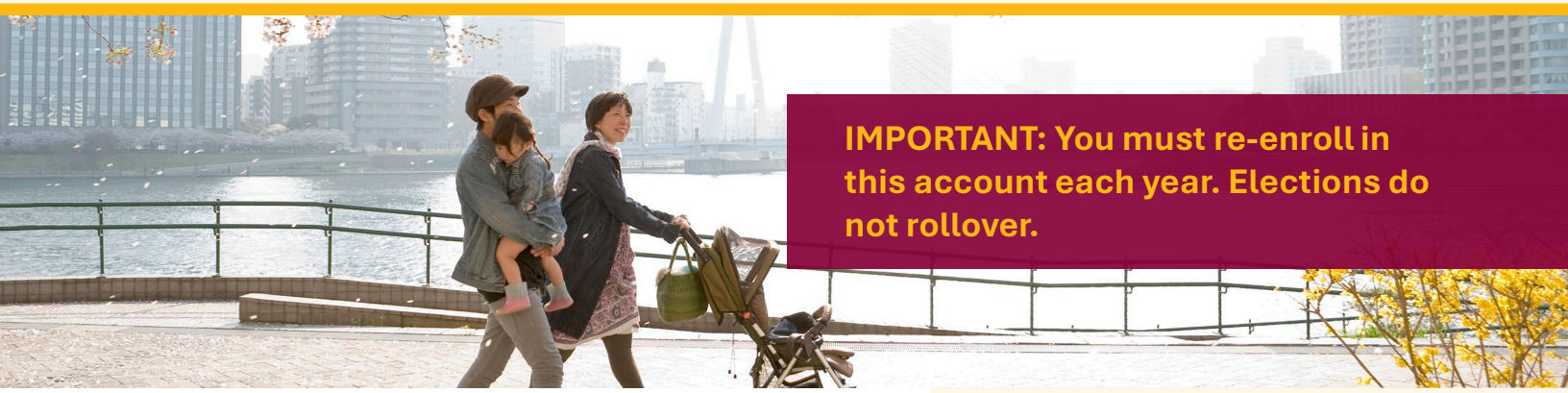
Your Monthly Benefit Costs for Medical

The total amount that you pay for your benefits coverage depends on the plans you choose and how many dependents you cover. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

Medical	SISC Blue Shield PPO 80K	SISC Blue Shield PPO 80M (HRA)	SISC Blue Shield PPO HSA $5,000 (HSA)	SISC Kaiser HMO $10 (HRA)
Employee Only	$0.00	$0.00	$0.00	$0.00
Employee + 1 Dependent	$75.25	$0.00	$0.00	$0.00
Family Coverage	$119.75	$0.00	$0.00	$0.00

NOTE: Hartnell College will continue to offer a Health Reimbursement Account (HRA) if enrolled in Blue Shield PPO 80M or Kaiser HMO $10 OV. Hartnell College will fund $200 per month into the HRA. If enrolled in the Blue Shield HSA $5,000, Hartnell College will fund $350 per month into the Health Savings Account (HSA).

Health Reimbursement Arrangement (HRA)



IMPORTANT: You must re-enroll in this account each year. Elections do not rollover.

Your "allowance" for healthcare expenses

Healthcare can be expensive. That's why eligible participants can access an HRA to help pay your medical expenses. The HRA is administered by American Fidelity.

Here's how it works

- Hartnell College sets aside a fixed amount of money into your HRA: $200 per month
- Your account will be funded monthly. You can use this money for yourself and your covered dependents.
- When you have a healthcare expense, you can use your HRA debit card or submit a request for reimbursement with a receipt. You can use your HRA for eligible expenses, until you've used up your funds.
- Eligible and Ineligible expenses

Are You Eligible?

You are eligible for the HRA if you are enrolled in the following plans:

- **SISC PPO 80M**
- **SISC Kaiser HMO $10**

Reasons to love an HRA

1. **It's 100% employer-funded.** All contributions are made by Hartnell College. In fact, the rules prohibit employee contributions.
2. **It's tax-free.** HRA reimbursements are excluded from your gross income, so they are 100% tax-free.
3. **You are eligible for an HRA as long as you remain in an HRA plan such as:**
    - Blue Shield 80m
    - Kaiser HMO $10

Can I have both an HRA and an FSA?

Yes! You can have both an HRA and a healthcare Flexible Spending Account (FSA) at the same time, but you can't be reimbursed from both accounts for the same expense. Generally, the HRA is used first until the account is depleted.

Can I have both an HRA and an HSA?

No! You can either have an HRA or an HSA, you can't have both.

Health Savings Account (HSA)

IMPORTANT: You must be enrolled in the SISC Blue Shield HSA $5,000 to be eligible for an HSA.

A Health Savings Account (HSA) is a powerful tool for managing healthcare costs and saving for the future. This program is administered through American Fidelity.

How the HSA Works

You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items. Your HSA account is set up automatically after you enroll.

2026 IRS Contribution Limits	**Individual**: $4,400 per year **Family**: $8,750 per year **Are you age 55 or over?** You can contribute an additional $1,000 per year
Hartnell College Contribution	To help you get started, Hartnell College contributes to your HSA (this is included in the IRS maximums noted above): $350 per month

You are ELIGIBLE for an HSA if:

- You are currently enrolled in SISC Blue Shield HSA $5,000.
- You are not enrolled in any other non-HDHP medical coverage.
- You do not have a general-purpose healthcare FSA through your own or your spouse's benefit plan. Limited purpose FSAs, which cover dental and vision expenses only, are allowed.

You are NOT ELIGIBLE for an HSA if:

- You are enrolled in Medicare, Medicaid or Tricare, or if you are someone else's tax dependent.

What about using your HSA for your dependents? Review this article to learn more: neb.alliant.com/hsa-eligibility-what-you-need-to-know/.

Unlock the Power of Your HSA

Tax Advantages
Contributions, growth and eligible withdrawals are all tax-free.*

Rollover Capability
Unused funds roll over from year to year, so you don't lose them.

Retirement Savings
You can use HSA funds for healthcare expenses in retirement.**

Flexibility
Use funds for a wide range of qualified healthcare expenses.

Portability
Keep your HSA even if you change jobs or health plans.

*California and New Jersey tax HSA contributions and interest.
**For more information regarding HSAs, Retirement and Medicare, please contact your tax advisor for advice.

Find out more

- American Fidelity
- Eligible and Ineligible Expenses

Dental

We offer dental coverage through ACSIG Delta Dental. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental Plan Overview

This guide serves as a summary of the dental plans. Please review the plan documents before enrolling in coverage.

	What you need to know
Delta Dental PPO	• No deductible • Out-of-network coverage; higher costs

Dental insurance covers multiple types of treatment:

1. **Preventive** care includes exams, cleanings and x-rays
2. **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
3. **Major** care goes further than basic and includes bridges, crowns and dentures
4. **Orthodontia** treatment to properly align teeth within the mouth.

Dental Plans

	ACSIG Delta Dental PPO - Core		ACSIG Delta Dental PPO – Buy-up (Optional)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	None		None	
Annual Plan Maximum	$1,650 per member	$1,500 per member	$2,500 per member	$2,500 per member
Diagnostic & Preventive				
Exams	70% - 100%	70% - 100%	70% - 100%	70% - 100%
Cleanings	70% - 100%	70% - 100%	70% - 100%	70% - 100%
X-rays	70% - 100%	70% - 100%	70% - 100%	70% - 100%
Basic Services				
Fillings	70% - 100%	70% - 100%	70% - 100%	70% - 100%
Root Canals	70% - 100%	70% - 100%	70% - 100%	70% - 100%
Periodontics	70% - 100%	70% - 100%	70% - 100%	70% - 100%
Major Services				
Crowns	70% - 100%	70% - 100%	70% - 100%	70% - 100%
Bridges	70%	70%	70%	70%
Implants	70%	70%	70%	70%
Orthodontia Adults and Children	50% up to $2,000 lifetime maximum	50% up to $2,000 lifetime maximum	50% up to $3,000 lifetime maximum	50% up to $3,000 lifetime maximum

What you need to know about this plan

Do I have to select a primary dentist? No

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

Where can I get more details? deltadentalins.com

Delta Dental Resources

SmileWay® Wellness Benefits

If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings. Opt in by visiting deltadentalins.com/smileway or by calling Customer Service Monday through Friday.

Delta Dental Mobile App

Anyone can use Delta Dental Mobile without logging in to access our Find a Dentist and Toothbrush Timer tools, conveniently located on the home screen. You also have the option to save your ID card to the home screen for easy access without logging in. Log into the app to view your personal benefits.

Virtual Dentistry

Virtual Dentistry is a photo-based tele-dentistry app for PPO plan members. Although Virtual Dentistry is not available for dental emergencies, members can set up a virtual dental screening or even send in photos for dental issues. A Delta Dental dentist that is part of the PPO Network, can highlight issues from the photos, such as cavities, gum disease, oral hygiene, or other dental concerns. The dentist can then assist with next steps or possible treatments or a home care regimen.

Cost Estimator

Members can plan visits and compare costs before they receive their treatments. Estimates for each member are personalized based on benefits. Members can compare procedure costs at nearby dentists should members need to plan in terms of costs. Members can also receive a detailed explanation of their costs based on upcoming treatment.

Amplifon & Qualsight Discounts

With the Amplifon discount, Delta Dental members get an average savings of 62% off the latest retail hearing aid price. PPO members may even be able to use their plan benefits in coordination with Amplifon discounts. There is also a QualSight discount for Delta Dental members. Members receive 40-50% off the national average price of traditional LASIK eye surgery when you use an experienced QualSight LASIK surgeon.

Finding a Delta Provider

To find a Delta Dental provider near you, please visit deltadentalins.com and click "Find a Dentist". For PPO plans choose "Delta Dental PPO"

Vision

We offer vision coverage through VSP. Vision coverage helps with the cost of eyeglasses or contacts.

Vision Plan Overview

This guide serves as a summary of the vision plans. Please review the plan documents before enrolling in coverage.

	What you need to know
ACSIG VSP	• Out-of-network coverage will have higher costs • The plan will reimburse up to a specific dollar amount for most materials

Click to play video

All About Vision

Watch this video to learn more about what to keep an eye out for when it comes to vision insurance.

Vision Plan

This table shows member cost share.

	ACSIG VSP Plan B	
	In-Network	**Out-of-Network Reimbursement**
Exams *Once every 12 months*	$10 copay	Up to $50
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens *Once every 12 months*	Covered in full after exam copay	Up to $50 Up to $75 Up to $100
Frames *Once every 24 months*	$170 Allowance	Up to $70
Contacts (Elective)[1] *Once every 12 months*	$170 Allowance	Up to $105

[1]In lieu of frames/lenses

What you need to know about this plan

What other services are covered?

The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?

Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA, limited purpose FSA, or HSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

Where can I get more details?

vsp.com

VSP Savings and Resources

Extra Savings on Glasses & Sunglasses

Get an extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. You can also save 30% on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.

TruHearing® Hearing Aid Discount

VSP® Vision Care members can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too. TruHearing also provides members with:

- 3 provider visits for fitting, adjustments, and cleanings
- A 45-day trial
- 3-year manufacturer's warranty for repairs and one-time loss and damage
- 48 free batteries per hearing aid

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call (877)396-7194.

Retinal Screening

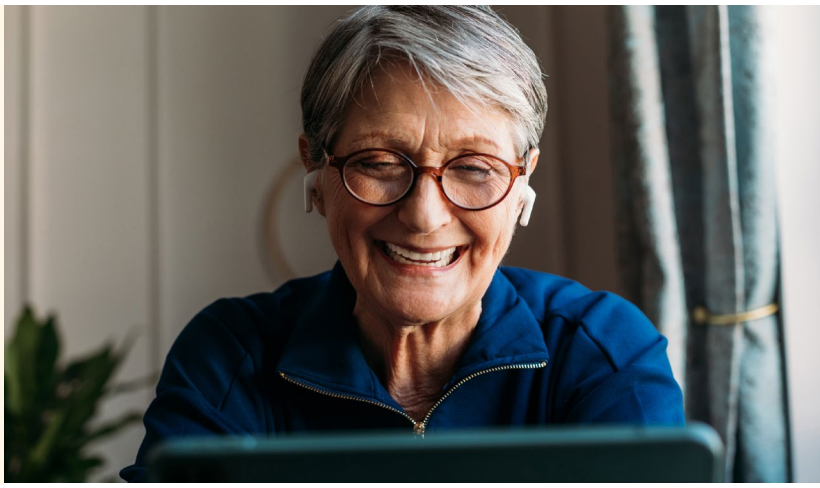
You won't pay more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.

LASIK - Laser Vision Correction

Save up to an average of 15% off the regular price of LASIK or 5% off the promotional price. Discounts are only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Access To Over $3,000 In Exclusive Member Savings

Visit vsp.com/offers to learn more about these resources and other VSP exclusive member extras.



Your Monthly Benefit Costs for Dental and Vision

The total amount that you pay for your benefits coverage depends on the plans you choose and how many dependents you cover. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

Dental and Vision	ACSIG Delta Dental Core Plan	ACSIG Delta Dental Buy-up Plan (Optional)	VSP Vision Plan B
Employee Only	$0.00	$13.20	$0.00
Employee + 1 Dependent	$2.47	$35.07	$0.25
Family Coverage	$6.22	$39.42	$0.82

SISC Value Added Services

Take advantage of these value added services available to SISC plan members to help you get and stay healthy.

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

SISC Value Added Services, Cont.

Benefit Highlights	Availability & How To Get Started
Virtual Expert Menopause Care **Midi Health**[1] Access to expert care for menopause through a specialized virtual clinic. The Midi team can provide personalized care for symptoms like hot flashes, mood changes, poor sleep, and more.	*Blue Shield PPO members* **Visit** joinmidi.com/sisc
Physical Therapy for Back or Joint Pain **Hinge Health** Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy.	*Blue Shield PPO members* **Call** (855) 902-2777 **Visit** hingehealth.com/sisc
24/7 Virtual Primary Care Doctor **Centivo Care** Virtually connect with a primary care physician to manage all your physical and mental healthcare needs. Centivo providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow up questions using video visits or live chat.	*Blue Shield PPO members* **Visit** centivocare.com or download the app
24/7 Access to Virtual Maternity & Postpartum Support **Maven** Connect with a care advocate who will guide you through various tools and resources related to pregnancy and postpartum care. Get private visits with gynecologists, specialists, therapists, and 30 other maternity and postpartum provider types.	*Blue Shield PPO members* **Visit** mavenclinic.com/join/SISC
Hip, Knee, & Spine Surgical Benefit **Carrum Health** Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.	*Blue Shield PPO members* **Call** (888) 855-7806 **Visit** info.carrumhealth.com/sisc
Enhanced Cancer Benefit **Lantern Cancer Care** Get help from a personal oncology nurse who can partner with you on every step of your cancer journey, including a review of your initial diagnosis and development of a care plan.	*Blue Shield PPO members* **Visit** lanterncare.com

[1] Not available to SISC HSA Members.

Life & Disability

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income.

Is your family protected?

Consider what your family would need to cover day-to-day living expenses and medical bills during an illness-related disability leave, or how you would manage large expenses after the death of a spouse or partner.

	Who is covered
Life and AD&D *Employer Paid*	• Employee • Spouse • Child
Life and AD&D *Voluntary*	• Employee • Spouse
Long Term Disability (LTD) *Employer Paid*	• Employee only

Your Beneficiary = Who Gets Paid

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

Company Provided Life and AD&D Insurance

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident.

Coverage is provided by Lincoln, and premiums are paid in full by Hartnell College.

Class description

Class I	All full-time active employees working 30 hours or more

Employee Life and AD&D Coverage

Class I	Employee: Flat $120,000

Note: Benefit amount reduces to 75% at age 60. *Refer to the plan document for details.*

Spouse and Dependent Life Coverage

Spouse	$1,500
Child(ren)	$1,500

A Note About Taxes

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Additional Features

- **Waiver of Premium** - An Insured Person's Life Insurance (and any Dependent Life Insurance) will be continued without payment of premium, if the Insured Person:
  - Becomes Totally Disabled while insured under the policy and before age 65
  - Remains Totally Disabled for at least 6 months; and
  - Submits satisfactory proof within the time period specified in the policy.
- **Accelerated Death Benefit** - If you become terminally ill, you may be eligible to receive up to 80% of your combined Basic and Additional Life benefit.
- **Conversion** - If your insurance ends or reduces, you may be eligible to convert your life insurance to an individual life insurance policy without submitting proof of good health. Premiums for the converted policy will be substantially higher compared to the Hartnell College sponsored term plan.

Voluntary Life Insurance

Protecting those you leave behind

Voluntary Life and AD&D Insurance allows you to purchase additional coverage to protect your family's financial security.

Coverage is provided by Lincoln Financial Group and available for you.

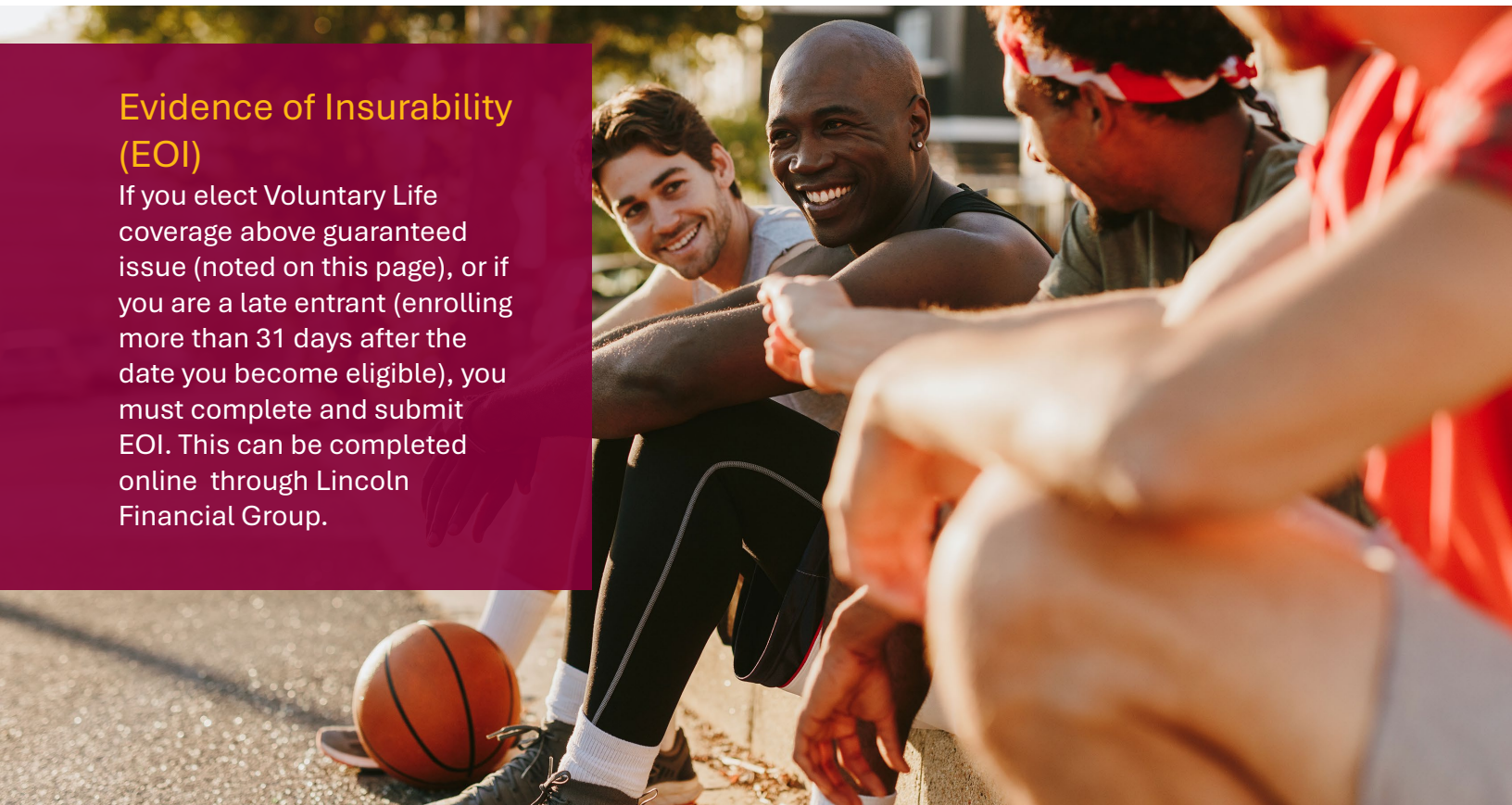
Voluntary Life and AD&D Coverage

Employee	Increments of $10,000 up to 5x the employee's annual salary **Guaranteed Issue:** Evidence of Insurability will be required for initial insurance

Note: Benefit amount reduces to 75% at age 60. *Refer to the plan document for details.*

Evidence of Insurability (EOI)

If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (enrolling more than 31 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Lincoln Financial Group.



Long-Term Disability Insurance

Long-Term Disability Insurance (LTD)

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Hartnell College pays the cost of this coverage. Coverage is provided by Lincoln Financial Group.

Class 1, 2, & 3	
Monthly Benefit amount	66.67% up to a maximum of $5,000
Benefits Begin	After 90 days of disability
Maximum Payment Period[1]	Class 1: To age 65 Class 2: lesser of 24 months

[1]Maximum payment period is based on the first day benefits begin, not the first day you are disabled.

What to Know About LTD Insurance

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.
4. Benefits are tax-free, since you pay the premiums with after-tax dollars.

Lincoln Value Added Services

WellnessPATH®

Lincoln WellnessPATH® provides tools and personalized steps to manage your financial life. From creating a budget to building an emergency fund to paying down debt, this easy-to-use online tool helps you turn information into action so you can focus on both short- and long-term goals, like saving for retirement. Contact your Human Resources contact to start using Lincoln WellnessPATH® today.

TravelConnect® Services

TravelConnect® services provide a wealth of medical, safety and travel-related services you can access while on a business or leisure trip more than 100 miles from home. It includes evacuation services, Travel Assistance services, and medical, dental and pharmacy referrals. To access call collect from anywhere in the world: +1(603) 328-1955 or Toll Free from US or Canada: (866) 525-1955.

FuneralPrep

Funeral planning through Lincoln Financial Group offers both pre-planning and at-need services at or near the time of need. You can access FuneralPrep by visiting the self-service online portal at LincolnFuneralPrep.com/GPlife or by connecting with a funeral planning consultant.

LifeKeys® Services

This program provides access to a wide array of services to help you and your loved ones through life's ups and downs — and prepare you for whatever lies ahead. Services include online will preparation, access to GuidanceResources® Online, protection against identity theft, and guidance and support for your beneficiaries. It's easy to access LifeKeys® services. Just call (855) 891-3684 or visit GuidanceResources.com. (First-time user: Enter Web ID LifeKeys).

EmployeeConnect℠

EmployeeConnect℠ offers professional, confidential services for both you and your loved ones. Receive up to 5 face-to-face counseling visits and one free 30-minute in person consultation per legal issue. It includes unlimited phone access 24/7 and web access to helpful articles, resources, and self-assessment tools. To access call (888) 628-4824 or visit GuidanceResources.com.

- Username: LFGSupport
- Password: LFGSupport1

Voluntary Plans

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs. You pay the entire cost for these plans through payroll deductions.

For more information regarding costs of coverage benefit offerings please visit AmericanFidelity.com.

Accident Insurance

Accident Insurance from American Fidelity helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

Cancer Insurance

Many people are concerned about the financial impact of a cancer diagnosis. Cancer insurance provides tax-free benefits for many of the costs associated with cancer treatment such as radiation, chemo, surgery, diagnostic tests, and physician charges. You can cover yourself and your family members if needed. American Fidelity provides coverage for this program.

Critical Illness Insurance

Critical illness insurance from American Fidelity can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

Hospital Indemnity Insurance

Hospital indemnity insurance from American Fidelity can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide.

Financial Wellness

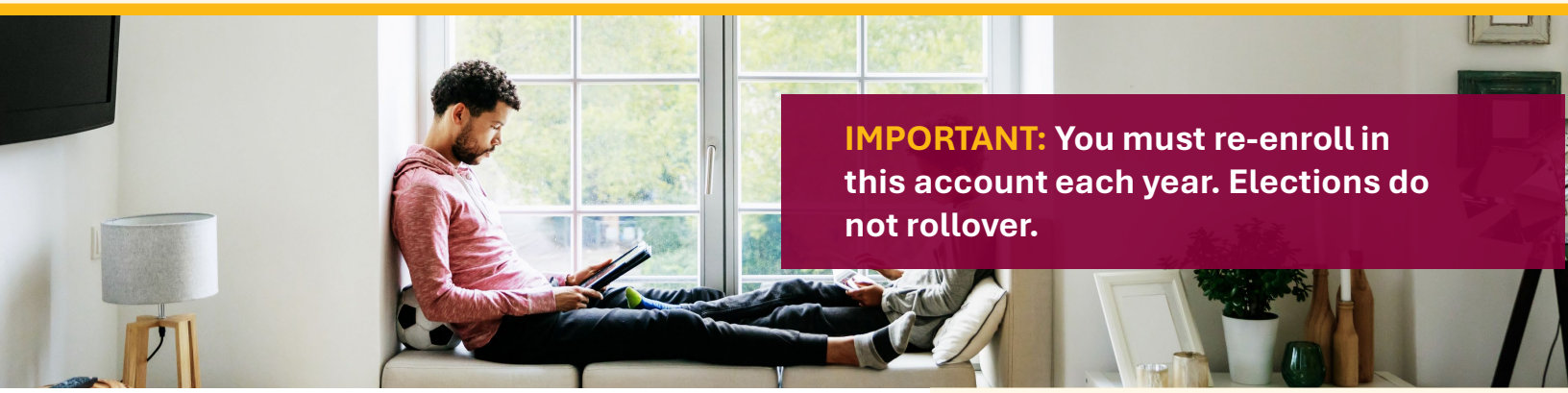
We offer benefits and resources to help you make the most of your money now and in the future.

Why Does Financial Wellness Matter?

Financial wellness directly impacts various aspects of your life, including physical and mental health, relationships, and career satisfaction. A strong financial footing reduces stress and anxiety related to money, leading to better mental health and overall quality of life. It enables you to pursue your goals, whether it's buying a home, starting a family, or planning for retirement, without the constant burden of financial worry.

	What you need to know
Healthcare Flexible Spending Account (FSA)	Use tax-free dollars for healthcare related expenses.
Dependent Care Flexible Spending Account (FSA)	Use tax-free dollars for childcare expenses.

Flexible Spending Account (FSA)



IMPORTANT: You must re-enroll in this account each year. Elections do not rollover.

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses. This program is administered through American Fidelity.

How the FSA Works

You estimate what you and your family's eligible out-of-pocket costs will be for the coming year, expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.

- Use the FSA debit card to pay for eligible services and products. You can also login to your online account or use your mobile app to request a payment be sent directly to your provider or to you.
- Request an itemized receipt for any expenses you plan to pay for with your FSA.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.

2026 IRS Contribution Limits	**You can contribute up to $3,300.** *Contributions are deducted from your pay pre-tax.*
Deadline To Incur Claims	Expenses must be incurred between January 1, 2026 and December 31, 2026
Deadline To Submit Claims	Claims must be submitted for reimbursement no later than December 31, 2025.
Rollover	You can rollover up to $660 to use the following year. Any additional remaining balance will be forfeited.

Are You Eligible?

All full-time active employees working 30 hours or more are eligible.

Limited Purpose FSA

- If you/your spouse are enrolled in a high-deductible health plan (like our CARRIER HSA plans), you can only participate in the Limited Purpose FSA for dental and vision expenses.
- All other considerations listed above also apply to the Limited Purpose FSA.

Do You Pay For Dependent Care?

Review page 30 for information on tax savings through the Dependent Care FSA.

Find out more

- AmericanFidelity.com
- Eligible and Ineligible Expenses

Comparing Tax-free Health Accounts

These program are administered through American Fidelity. Visit AmericanFidelity.com to learn more.

	Health Savings Account (HSA)	Healthcare Flexible Spending Account (FSA)
Who can participate?	SISC Blue Shield HSA $5,000 participants	Anyone not enrolled in an HDHP plan. Some employers offer HDHP members a "Limited Purpose FSA" for dental/vision expenses only.
Is the account tax-free?	Contributions, earnings, and withdrawals for qualified healthcare expenses are free from federal tax. *	Contributions and withdrawals for qualified healthcare expenses are tax-free.
Who funds the account?	Hartnell College makes a contribution to your HSA account: $350 per month You can make additional contributions, up to the annual limit.	FSA accounts are funded by your payroll deductions.
How much can I contribute?	Your and your employer's contributions can total $4,400 per individual or $8,750 per family in 2025, plus $1,000 if you're over 55.	$3,300 in 2025
Does my unused balance roll over?	100% of balance.	Some FSA plans allow a rollover of up to $660 from 2025 funds.
What is the deadline to incur claims?	N/A	You have until December 31, 2026, to incur new claims.
What is the deadline to submit claims?	N/A	You have until December 31, 2026, to submit new claims.
What happens if I leave the company?	Your account goes with you. You can use it for future qualified healthcare expenses, even if you no longer have an HDHP health plan.	You may finish your current FSA plan year through COBRA.
Does my account earn interest?	Yes, and you can invest your account balance over a certain amount in investment accounts, just like a 401(k).	No
Can I change my election after open enrollment?	Election can be changed mid-year, and deposits can be made at any time.	Election cannot be changed unless you have a qualifying life event.
When can I spend my funds?	After they are deposited into the account.	Immediately, up to your total annual election.

*California and New Jersey tax HSA contributions and interest.

Additional Tax-Saving Accounts

IMPORTANT: You must re-enroll in this account each year. Elections do not rollover.

Dependent Care Flexible Spending Account (FSA)

Paying For Daycare? Make It Tax-free! A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by American Fidelity.

How the Dependent Care Flexible Spending Account (FSA) Works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

2026 IRS Contribution limits	**You can contribute up to $7,500 per household per year.** If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $3,750 each year
Deadline to incur expenses	Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year, January 1st, 2026, to December 31st, 2026
Rollover	Unspent funds will be forfeited.

You can't change your Dependent Care FSA election amount mid-year unless you experience a qualifying event.

Find out more

- AmericanFidelity.com
- Eligible and Ineligible Expenses

Every Opportunity To Save

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Wellbeing & Balance

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

A Happier, Healthier You

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

	What you need to know
Employee Assistance Program (EAP)	Access resources to manage stress, chemical dependency, mental health and family issues.
Time Away From Work	Take time to spend with family and friends, take care of personal business, or just have a little extra "me time".

Important

For immediate assistance in a mental health crisis please call 911. Or call the National Suicide Prevention Lifeline at 988 for a national network of local crisis centers that provides free and confidential emotional support.

Employee Assistance Program (EAP)

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Anthem can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues
- Unlimited web access to helpful articles, resources, and self-assessment tools

Available Resources

Counseling Benefits

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

Parenting & Childcare

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

Financial Coaching

- Money management
- Debt management
- Identity theft resolution
- Tax issues

Legal Consultation

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Eldercare Resources

- Help with finding appropriate resources to care for an elderly or disabled relative

Online Resources

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

Contact the EAP

Phone

800-999-7222

Website

anthemEAP.com

LEAVES OF ABSENCE

There is no perfect, one-size-fits-all balance between work and home. We provide time off so you can take some "me time" to relax, recover from illness, and take care of personal and family business.

	Medical Leave Act (FMLA)
Eligibility	You must have worked for the District for at least 12 months, worked at least 1250 hours in the previous 12 months, and you must not have exhausted 12 weeks of FMLA in the preceding year.
Eligible Events	Due to your own serious health condition, to care for your spouse, your child (under 18 years old) or parent with a serious health condition, or to bond with a new child due to birth, adoption, or foster care.
Leave Duration	Up to 12 work weeks.
Wages	FMLA leave is unpaid; however, you are required to use available sick leave. For more information refer to your collective bargaining unit agreement.

	California Family Rights Act (CFRA)
Eligibility	You must have worked for the District for at least 12 months, worked at least 1250 hours in the previous 12 months, and you must not have exhausted 12 weeks of CFRA in the preceding year.
Eligible Events	Due to your own serious health condition, to care for your spouse, domestic partner, child, parent, parent-in-law, grandparent, grandchild, sibling, or designated person with a serious health condition, or to bond with a new child due to birth, adoption, or foster care.
Leave Duration	Up to 12 work weeks.
Wages	CFRA leave is unpaid; however, you are required to use available sick leave. For more information refer to your collective bargaining unit agreement.

	Pregnancy Disability Leave (PDL)
Eligibility	Provides leave for an individual disabled due to pregnancy or a pregnancy-related condition. PDL can include reasonable accommodation such as modified work duties.
Leave Duration	Up to 4 months based on hours worked per week and duration of disability.
Wages	PDL leave is unpaid; however, you are required to use available sick leave. For more information refer to your collective bargaining unit agreement.

Do you need additional assistance?

For support or questions, please email benefits@hartnell.edu or call (831) 755-6706.

2026 HOLIDAYS

Hartnell College provides 13 holidays per year.

MLK Day	January 19th, 2026
Lincoln's Birthday	February 12th, 2026
Washington's Birthday	February 16th, 2026
Cesar Chavez Day	March 31st, 2026
Memorial Day	May 25th, 2026
Juneteenth	June 19th, 2026
Independence Day	July 3rd, 2026
Labor Day	September 7th, 2026
Native American Day	October 12th, 2026
Veterans' Day	November 11th, 2026
Thanksgiving	November 26th, 2026
Friday after Thanksgiving	November 27th, 2026
Winter Holiday Break	December 25th – January 1st

Important Plan Information

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

	What you need to know
Important Contacts	Contact information for our benefit carriers and vendors.
Benefits Glossary	A Benefits Glossary to help you understand important insurance terms.
Important Notices	A summary of the health plan notices you are entitled to receive annually, and where to find them.

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

Plan Contacts

If you have questions about what is covered, here is the plan contact information for each plan:

Plan Type	Provider	Phone Number	Website/Email	Policy No.
Medical	SISC Blue Shield	855-599-2657	Self-Insured Schools of California | Anthem	
	SISC Kaiser	800-464-4000	Custom Care & Coverage Just For You | Kaiser Permanente	
Prescription Benefit Manager	Navitus Health Solutions	866-333-2757	Navitus.com	
Prescription Mail Order though Costco	Costco Pharmacy Mail Order	800-607-6861	Welcome to Costco Pharmacy	N/A
Dental	Delta Dental	866-499-3001	Plans for individuals and groups | Delta Dental	07046
Vision	VSP	800-877-7195	VSP Vision Care | Vision Insurance	30098994
Life & Disability	Lincoln	1-877-275-5462	Lincoln Financial | Life and Disability	1284302
Voluntary Plans	American Fidelity	866-504-0010	American Fidelity | Voluntary Plans	MCP33803
Employee Assistance Program (EAP)	Anthem EAP	800-999-7222	Welcome to EAP: Member Log-in | Anthem	N/A

Glossary

-A-

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

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

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

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

-B-

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

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

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

-C-

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

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

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

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

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.
Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

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

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

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

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

-E-

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

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

-F-

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

-G-

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

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

-H-

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

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

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

Glossary

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

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

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

-S-

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

-T-

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

-U-

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

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

-V-

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

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

Important Plan Information

Health Plan Notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located here.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **The 'No Surprises' Rules:** Explains rules that protect you from surprise medical bills
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents

COBRA Continuation Coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

Medicare Part D Notice

Important Notice from Hartnell College About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your Hartnell College coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **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. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

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

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

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

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

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

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

Contact the person listed below for further information.NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Hartnell College changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	1/1/2026
Name of Entity/Sender:	Hartnell College
Contact-Position/Office:	Benefits Department
Address:	411 Central Ave. Salinas, CA 93901
Email:	Benefits@Hartnell.edu

Women's Health and Cancer Rights Act

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

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

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

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.

HIPAA Notice of Special Enrollment Rights

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

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

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

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

Availability of Privacy Practices Notice

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

Notice of Choice of Providers

The health plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator.

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

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

ACA Disclaimer

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

The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **July 31, 2025**. Contact your State for more information on eligibility—

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

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

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.

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