2023-2024
ACTIVE BENEFITS

BENEFITS FOR YOUR LIFE

Santa Clara County
Office of Education

CONTENTS

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

GETTING STARTED

2023-2024 BENEFITS

October 1, 2023 through September 30, 2024

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, The **Santa Clara County Office of Education** 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, retirement benefits, 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.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

Permanent employees eligible according to their respective bargaining unit agreement or handbook

Eligible dependents

- Legally married spouse or domestic partner
- Natural, adopted or stepchildren 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).

For additional information, please refer to each benefit in this booklet.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the 1st of the month following your date of hire as long as you enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

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).

You must submit your change within 30 days after the event.

MEDICAL

OUR PLANS

Anthem Blue Cross PPO

Anthem Blue Cross PPO Deductible

Anthem Blue Cross PPO High Deductible

Kaiser HMO

Kaiser HMO Deductible

Kaiser HMO High Deductible

WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations:

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

Anthem Blue Cross Medical Comparison

	Anthem PPO – 100-$20; Rx 5-20		Anthem PPO – 80-G $20; Rx 7-25		Anthem HDHP; Rx 9-35	
Annual Deductible	$0		$500 per individual / $1,000 per family		$3,000 per individual / $5,200 per family	
Annual Out-of-Pocket Maximum	$1,000 per individual up to $3,000 per family		$2,000 per individual / $4,000 per family		$5,000 per individual / $10,000 per family	
Office Visit	$20 copay		$20 copay		10% after deductible	
Acupuncture	No copay up to 12 visits		20% after deductible, up to 12 visits		10% after deductible	
Lab and X-ray	No copay		20% after deductible		10% after deductible	
Emergency Room	$100 copay, waived if admitted		$100 copay, waived if admitted, then 20% after deductible		$100 copay, waived if admitted, then 10% after deductible	
Hospitalization	No copay		20% after deductible		10% after deductible	
Outpatient Surgery	0%		20% after deductible		10% after deductible	
PRESCRIPTION DRUGS						
	SISC Rx Plan 5-20		**SISC Rx Plan 7-25**		**SISC Rx Plan 9-35**	
Out-of-Pocket Maximum	$1,500 individual/ $2,500 family		$1,500 individual/ $2,500 family		Included in Medical Out of Pocket Maximum	
	30-day supply	90-day supply	30-day supply	90-day supply	30-day supply	90-day supply
Most Generic Drugs	$5	$0	$7	$0	$9	$0
Single Source Brand Name Drugs	$20	$50	$25	$60	$35	$90
Multi Source Brand Name Drugs	$5 + brand / generic cost difference	$15 + brand / generic cost difference	$7 + brand / generic cost difference	$18 + brand / generic cost difference	$9 + brand / generic cost differen ce	$26 + brand / generic cost difference
Brand Only	Not Applicable		Not Applicable		Subject to medical deductible	

Kaiser Medical Plan Comparison

	Kaiser HMO	Kaiser - DHMO	Kaiser – HDHP (HSA)
Annual Deductible	$0	$500 per individual / $1,000 per family	Individual coverage: $1,500/$1,700* Family Coverage: $3,000/$3,400* *Increased amounts effective 1/1/2024
Annual Out-of-Pocket Maximum	$1,500 per individual up to $3,000 per family	$3,000 per individual / $6,000 per family	$3,000 per individual / $3,400 per individual $6,000 per family/ $6,800 per family *Increased amounts effective 1/1/2024
Office Visit	$20 copay	$20 copay (deductible waived)	10% after deductible
Chiropractic / Acupuncture	$10 copay (chiro/acupuncture combined) (30 visits/year)	$10 copay (chiro/acupuncture combined) (30 visits/year)	10% after deductible (physician referral required)
Lab and X-ray	No copay	Complex imaging: $50; all others $10	10% after deductible
Emergency Room	$100 copay, waived if admitted	10% after deductible	10% after deductible
Hospitalization	No copay	10% after deductible	10% after deductible
Outpatient Surgery	$20 per procedure	10% per procedure after deductible	10% after deductible

PRESCRIPTION DRUGS						
	Kaiser Rx Plan 10-20		Kaiser Rx Plan 10-30 (DHMO)		Kaiser Rx Plan (copays after deductible)	
Out-of-Pocket Maximum	Included in Medical Out of Pocket Maximum					
	30-day supply	100-day supply	30-day supply	100-day supply	30-day supply	100-day supply
Most Generic Drugs	$10	$10	$10	$20	$10	$20
Single Source Brand Name Drugs	$20	$20	$30	$60	$30	$60
Multi Source Brand Name Drugs	$20	$20	$30	$60	$30	$60
Brand Only	Not Applicable		Not Applicable		Subject to medical deductible	

ginger

Now Available to Kaiser Permanente Members

The Ginger app offers 1-on-1 support for many common challenges — from anxiety, stress, and low mood to issues with work, relationships, and more. Ginger's skilled emotional support coaches are ready to help 24/7. Kaiser Permanente members can use the app at no cost, no referral needed. [1,2,3,4]

What can you do with Ginger?

- Text with your coach on the Ginger app now or schedule a time to connect later.
- Discuss goals, share challenges, and create an action plan with your coach.
- Get personalized, interactive skill-building tools from your coach and a library of more than 200 activities on the app.
- View recaps from each texting session and track your progress.
- Work with your coach to adjust your action plan if needed to better help you reach your goals.

Ginger's emotional support coaching can help employees with anxiety 47% of Ginger users with anxiety saw their symptoms improve.

Around-the-clock support is always available

Employees can access personalized support in their moment of need.

Download Ginger now at kp.org/coachingapps/ncal

1. The Ginger app and coaching services described above are not covered under your health plan benefits, are not a Medicare-covered benefit, and are not subject to the terms set forth in your Evidence of Coverage or other plan documents. These services may be discontinued at any time without notice. The app and coaching services are not available to any members under 18 years old. **2**. The app and coaching services are neither offered nor guaranteed under contract with the FEHB Program, but are made available to enrollees and family members, 18 and older, who become members of Kaiser Permanente. **3**. The app and coaching services are not available to Medi-Cal members. **4. Kaiser Permanente members can text with a coach using the Ginger app for 90 days per year. After the 90 days, members can continue to access the other services available on the Ginger app for the remainder of the year at no cost**

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- SISC Flex
- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the Healthcare FSA works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,050. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you forfeit the leftover balance at the end of the year.

FSA TAX SAVINGS EXAMPLE

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,750 FSA Contribution

$684 24% Federal income tax	**$219** 7.65% FICA tax	**$903** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

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?

Dependent Care FSA—up to $5,000 per year 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 SISC Flex.

Here's how the Dependent Care 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 set aside up to $5,000 per household, $2,500 if married and filing separately, per year. 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.

Estimate carefully! You can’t change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

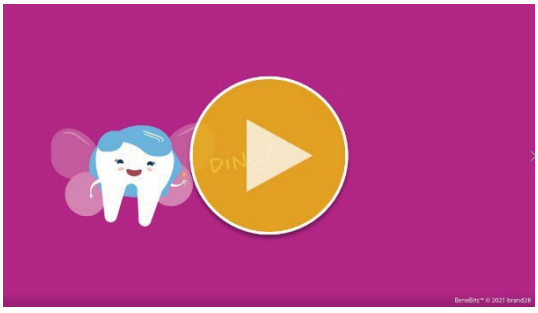
DENTAL

OUR PLANS

Delta Dental PPO – Economy Plan

Delta Dental PPO – Core Plan

Click to play video



Why sign up for Dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

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

Delta Dental PPO – Economy Plan

	In-Network Benefits	Out-of-Network Benefits
Annual Deductible	None	None
Annual Plan Maximum	$2,000 per individual	$1,500 per individual
Diagnostic & Preventive	100%	70-100%
Basic Services	70-100%	70-100%
Major Services	70-100%; Bridges and dentures: 70%	70-100%; Bridges and dentures: 70%
Orthodontia (adults / children)	50%	50%
Ortho **Lifetime** Max	$1,000	$1,000

Delta Dental PPO – Core Plan

	In-Network Benefits	Out-of-Network Benefits
Annual Deductible	None	None
Annual Plan Maximum*	$4,000 per individual	$4,000 per individual
Diagnostic & Preventive	100%	70-100%
Basic Services	70-100%	70-100%
Major Services	70-100%; Bridges, dentures & implants: 100%	70-100%; Bridges, dentures & implants: 100%
Orthodontia (adults / children)	100%	100%
Ortho **Lifetime** Max	$5,000	$5,000

**Preventive care does not apply towards your annual plan maximum*

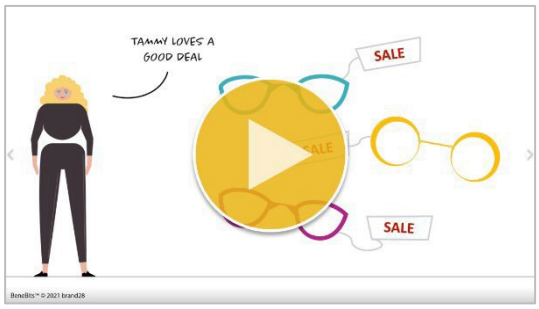
**All services, including major services, are covered up to your annual plan maximum*

VISION

OUR PLANS

VSP Vision

Click to play video



Why sign up for Vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

VSP Vision

	In-Network Benefits	Out-of-Network Benefits
Copay	**Exam & Materials:** No Copay	**Exam & Materials:** Reimbursed up to $60
Frames	Up to $300 allowance	Reimbursed up to $75
Lenses	**Single Vision:** 100% of basic lens **Bifocal:** 100% of basic lens **Trifocal:** 100% of basic lens **Progressive:** 100% of basic lens	**Single Vision:** Reimbursed up to $55 **Bifocal:** Reimbursed up to $75 **Trifocal**: Reimbursed up to $90 **Progressive**: Reimbursed up to $90
Contacts (Elective)	$300 allowance (instead of eyeglasses)	Reimbursed up to $175 (in-network limitations apply)
Frequency	**Exam:** Every 12 months **Frames:** Two frames in any 24 consecutive months **Lenses**: Two pairs in any 24 consecutive months	**Exam:** In-network limitations apply **Frames:** In-network limitations apply **Lenses**: In-network limitations apply

Employee Assistance Program (EAP)

EAP is designed to help you with everyday concerns and questions, both big and small, which impact you or anyone residing in your household. These include:

Relationship difficulties

Marriage, family or parenting concerns

Managing change & stress

Grief & loss

Legal & financial problems

Work-related concerns

Anxiety & depression

The EAP can assist you with more serious concerns such as alcohol and drug problems, family violence and threats of suicide. EAP resources are most effective when the services are accessed early in the progression for a problem, before the situation begins to impact personal life or work.

When you or a household member contacts the EAP, they work with you to figure out the next steps. If you need counseling, we arrange for up to 6 visits with a licensed professional. If you have money concerns or legal questions, we put you in touch with a financial advisor or an attorney.

FEATURES OF THE EAP INCLUDE:

- An employee assistance program is available to all regular employees. This includes family members, domestic partners and anyone residing in the employee/retiree's home.
- There is no cost for EAP services; no co-pays or forms required
- Up to 6 sessions per issue are available in person or via virtual visit
- Evening appointments, which reduce time off the job
- Emergencies handled by staff members available by phone 24 hours a day on a toll-free basis
- Every effort is made to see clients within 48 hours
- Appointments are scheduled at member's convenience
- People in crisis are provided same-day service
- Accessible via phone (800) 999-7222 or by registering on the EAP website: www.AnthemEAP.com and enter program name: **SISC**

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	• Identifying symptoms • Decide if immediate care is needed • Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	• Cold, flu, allergies • Headache, migraine • Skin conditions, rashes • Minor injuries • Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7	**$$$$$**

PREVENTIVE CARE SCREENING BENEFITS

TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **cdc.gov/prevention** for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan carrier.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

LIFE & DISABILITY

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.

Is your family protected?

Life, AD&D and disability insurance can fill several financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide long-term disability benefits and life and AD&D insurance to help you recover from financial loss.

BASIC LIFE AND AD&D

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. The cost of coverage is paid in full by the Santa Clara County Office of Education.

The Standard Basic Life and AD&D

ELIGIBILITY

- Superintendent, Certificated Management, Classified Management, Psychologist, Supervisory and Confidential - $50,000
- All Other Members - $20,000

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for full information & details

BUSINESS TRAVEL AD&D

Business Travel Accident insurance is available to all eligible employees through Mutual of Omaha at no cost. This insurance protects you from accidental death or dismemberment that may occur while traveling on assignment with authorization of the Santa Clara County Office of Education.

Benefits	Coverage Details
Eligibility	
All employees who work at least 17.5 hours or more per week traveling on assignment or with authorization of the District for the purpose of furthering the business of the District	
Benefits	$100,000
Aggregate Limit of Indemnity	$1,500,000
AD&D Benefits	"Member" means hand, foot, or eye
Loss of Life	100% of the Principal Sum
Loss of Two Members	100% of the Principal Sum
Loss of One Member	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum

This plan does not cover accidents resulting from suicide or attempted suicide, war, traveling between the insured's residence and regular place of employment or while on vacation or an authorized Leave of Absence. The plan also does not cover injuries sustained by an insured who, at the time of the accident, or performing duties usual with those of a driver of a bus or van then owned or being leased, rented, on to or operated by the District; or injuries received while traveling in any aircraft which is owned or leased by the District or by an employee or School Board Member or any other injuries received while traveling by air, except as described in the Description of Benefits

PERSONAL AD&D

All employees are covered with a basic $1,000 policy at no cost. This plan, administered by New York Life, offers employees the opportunity to purchase additional Personal Accident and AD&D benefits. You have an opportunity to purchase coverage for your spouse and/or children.

You may buy additional coverage for you and your family. Your spouse's benefit amount will be 40% of yours or 50% if you have no dependent children. Each of your covered children's benefit amount will be 10% of yours, or 15% if you are a single parent.

Benefits	Coverage Details
Eligibility	Active full-time employees working a minimum of 15 hours or more per week
Benefits	$1,000
AD&D Benefits	
Loss of Life	100% of Benefit
Loss of any combination of two: hands, feet, or eyesight	100% of Benefit
Loss of speech and hearing in both ears	100% of Benefit
Loss of one hand, foot, or sight in one eye	50% of Benefit
Loss of speech or hearing in both ears	50% of Benefit
Loss of thumb and index finger of the same hand	25% of Benefit

Please refer to the plan summary for the Benefit Reduction totals

SHORT-TERM DISABILITY (STD)

Short-Term Disability coverage pays you a benefit if you temporarily can't work because of an injury, illness, or maternity leave. Benefits may be reduced by income from other sources such as paid time off (e.g. sick time, donated sick leave, workers compensation temporary disability benefits). Employees covered under the CTA bargaining unit agreement are not eligible and may purchase a policy through American Fidelity or The Standard.

Benefits	California State Disability
Eligibility	All Members of SEIU
State Disability (SDI)	SDI is a partial wage-replacement insurance plan for California workers. The SDI program is state-mandated and funded through employee payroll deductions. SDI provides affordable, short-term benefits to eligible workers. Workers covered by SDI are covered by two benefits: Disability Insurance (DI) and Paid Family Leave (PFL)
Disability Insurance (DI)	Disability Insurance provides affordable, short-term benefits to eligible workers who suffer a loss of wages when they are unable to work due to a non-work-related illness or injury, or due to pregnancy or childbirth
Paid Family Leave (PFL)	Paid Family Leave (PFL) was established for workers who suffer a loss of wages when they need to take time off from work to care for a seriously ill child, spouse, parent, or registered domestic partner, or to bond with a new child. California workers may be eligible to receive PFL benefits when taking take time off work to care for a seriously ill parent-in-law, grandparent, grandchild, or sibling
Benefits	**Keenan & Associates**
Eligibility	All active full-time or permanent part-time Management, Supervisory, Confidential, & Psychologists working 17.5 hours or more per week
Elimination period	Minimum of 30 calendar days of disability and exhaustion of accumulated sick leave (whichever occurs later)
Benefit Percentage	66 2/3% of Basic Monthly Earnings
Maximum Monthly Benefit	$8,889.00 per month
Minimum Monthly Benefit	$100.00 per month
Benefit Reductions	Social Security, State Disability and Workers' Compensation
Maximum Benefit Duration	270 Consecutive Calendar Days

LONG-TERM DISABILITY (LTD)

THINGS 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.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance, offered through The Standard, 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. Eligible employees are covered at no cost.

Employees covered under the CTA bargaining unit agreement are not eligible and may purchase a policy through American Fidelity or The Standard.

	Coverage Details		
Eligibility	Must be a regular employee of the Santa Clara County Office of Education, who works at least 17.5 hours each week and is either a citizen or resident of the United States or Canada		
Psychologists and Leadership Team Members	66 2/3% of the first $13,334 of monthly pre-disability earnings, reduced by deductible income		
SEIU Members	66 2/3% of the first $8,334 of monthly pre-disability earnings, reduced by deductible income		
Benefits	**Monthly Benefit**		
	Maximum Monthly Benefit	**Minimum Monthly Benefit**	**Benefit Waiting Period**
Psychologists and Leadership Team Members	$8,889.00	$100.00	270 days
SEIU Members	$5,556.00	$100.00	30 days

VOLUNTARY DEDUCTIONS

Tax Shelters	Credit Unions
457 Plan For more information contact: **Employee Benefits Services & Advisors, Inc.** 535 Millich Dr., Suite 100 Campbell, CA 95008 408.978.1000 ***ebenefitsservices.net***	**Provident Credit Union** 303 Twin Dolphin Drive Redwood City, CA 94065 800.632.4600 ***www.providentcu.org***
403b Plan There are many companies to choose from. The list of approved 403b vendors may be viewed on the internet at: ***403bcompare.com*** An account **must** be established with the company you select **before** any deductions can be processed	**Santa Clara County Federal Credit Union** Located inside the Santa Clara County Government Center Building (lower level) 70 West Hedding Street San Jose, CA 95110 408.282.0700 ***www.sccfcu.org***
	Commonwealth Central Credit Union 5890 Silver Creek Valley Road San Jose, CA 95138 408.531.3100 ***www.wealthcu.org***
Other Voluntary Deductions	
Income Protection – Disability Insurance • ACE /CTA Standard - **(for CTA only)** ***The Standard*** • American Fidelity – 866.504.0010 ***American Fidelity***	**Section 125 Plan through Navia (SISC)** (800) 972-1727 Flexible Spending Accounts (FSA) Unreimbursed Medical & Dependent Day Care ***www.naviabenefits.com***
Supplemental Life Insurance • ACE/CTA Standard – **(for CTA only)** ***The Standard***	**Commuter Benefits** Commuter Check – Edenred – 888.235.9223 ***www.commuterbenefits.com/employees***
Accident Insurance • New York Life Insurance (Insurance Company of North America) - 800.644.5567 ***https://www.mynylgbs.com/auth*** ***or email*** ***ClientGuide@newyorklife.com***	

MODERN HEALTH

Santa County Office of Education offers Modern Health benefits to employees and their dependents as part of our continued efforts to prioritize workplace well-being.

What is Modern Health?
Modern Health is a mental wellness platform that makes it simple for you to access personalized care for life's ups and downs — whether at work, at home, or in your relationships.

Answer a few questions about your well-being, and Modern Health will thoughtfully guide you to resources that align with your needs and preferences. Watch this brief video to learn more!

How can Modern Health benefit you?
Personalized Support: Get support in the areas that matter to you — whether that's stress & anxiety, burnout, parenting, work performance, relationships, challenging life events, finances, or others.
Mental Resilience: Gain clarity on how to navigate challenges in your life, create healthy habits, build confidence, and improve your overall mental well-being.
Find Community: You'll have access to group support sessions, designed to be safe spaces to listen, share, and learn with others.

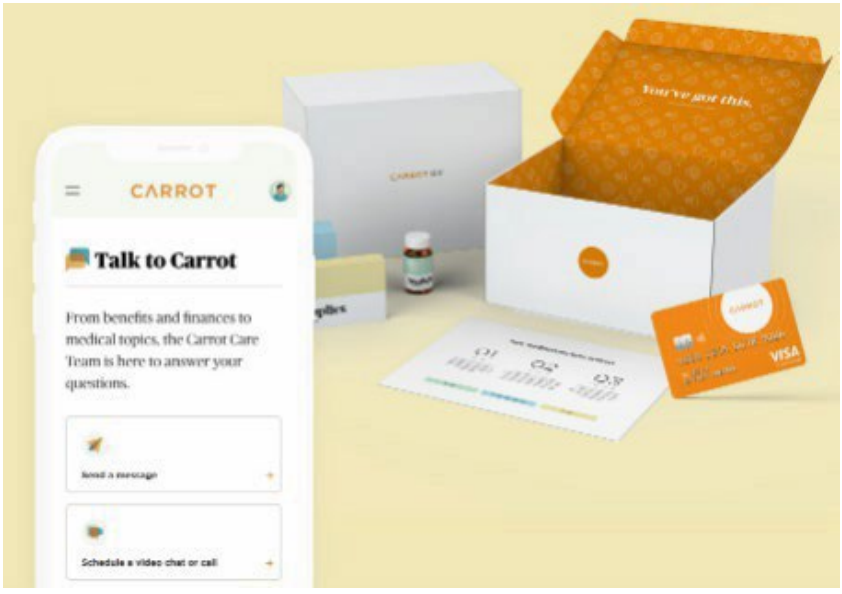
You'll have access to:
10 1:1 sessions with certified mental health, professional, or financial well-being coaches
8 1:1 sessions with licensed clinical therapists
Unlimited group support sessions (called Circles)
A library of guided meditations & self-paced digital courses
Ongoing well-being assessments to check-in on your well-being over time

CARROT FERTILITY

Santa Clara County Office of Education has partnered with Carrot to make fertility care and family forming more accessible and affordable for you and your eligible spouse. Regardless of your path, Carrot provides support for each step along the way.

Under the **Pro Plan**, employees have:

- Access to 3,600 clinics and 2,500 attorneys and more available globally
- Expert guidance through personalized plans and educational content
- At-home care through Telehealth to experts plus advanced wearables
- Carrot RX, a premium pharmacy w ith significant savings and convenient delivery
- Access to the payment platform, including claims adjudication & Carrot Card
- Carrot GPS, an expert care team to assist in growing employee knowledge with Carrot Fertility



Visit www.get-carrot.com/signup to create your account and explore the resources available to you, including the funds provided to help pay for your care.

Have Questions? Visit www.get-carrot.com/employee-support to connect with your care team!

IMPORTANT PLAN INFORMATION

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

- Your medical, dental and vision benefit contributions for 2023-2024
- Contact information for our benefit carriers and vendors
- A Benefits Glossary to help you understand important insurance terms
- A summary of the health plan notices you are entitled to receive annually, and where to find them

PLAN CONTACTS

MEDICAL, DENTAL & VISION

Anthem Blue Cross
Classified Policy # 40428A
Certificated Policy # 40449A
Leadership Policy # 40456A
Anthem.com/ca/sisc
(800) 825-5541

Anthem Deductible
Classified Policy # 40428B
Certificated Policy # 40449B
Leadership Policy # 40456B
Anthem.com/ca/sisc
(800) 825-5541

Anthem High Deductible
Classified Policy # 40428C
Certificated Policy # 40449C
Leadership Policy # 40456C
Anthem.com/ca/sisc
(800) 825-5541

Navitus (Anthem Pharmacy Service)
Navitus.com
(866) 333-2757

Kaiser HMO
Classified Policy # 606394-0127ALN
Certificated Policy # 606394-0127ACN
Leadership Policy # 606394-0127AMN
Kp.org
(800) 464-4000

Kaiser Deductible
Classified Policy # 606394-0128ALN
Certificated Policy # 606394-0128ACN
Leadership Policy # 606394-0128AMN
Kp.org
(800) 464-4000

Kaiser High Deductible
Classified Policy # 606394-0023ALN
Certificated Policy # 606394-0023ACN
Leadership Policy # 606394-0023AMN
Kp.org
(800) 464-4000

Delta Dental
Policy # 934
Deltadentalins.com
(866) 499-3001

Vision Service Plan (VSP)
Policy # 30098994
vsp.com
(800) 877-7195

EAP

Anthem EAP
Policy # SISC
Anthemeap.com
(800) 999-7222

FLEXIBLE SPENDING ACCOUNTS (FSA)

Navia (through SISC)
Sisc.kern.org/flex
(800) 972-1727

HEALTH SAVINGS ACCOUNT (HSA)

Optum Bank
www.optumbank.com/health-accounts/hsa.html
(866) 234-8913

ADDITIONAL BENEFITS

Modern Health
https://www.modernhealth.com/

Carrot Fertility
www.get-carrot.com/learnmore

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).

Note: Beginning January 1, 2022 the "No Surprises Act" provides protections against surprise billing for emergency services, air ambulance services, and certain services provided by a non-participating provider at a participating facility. For these services, the member's cost are generally limited to what the charge would have been if received in-network, leaving any balance to be settled between the insurer and the out-of-network provider. Consult your health plan documents for details.

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 under age 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.

GLOSSARY

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.

-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 / Teledoc
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.

2023 IMPORTANT PLAN NOTICES AND DOCUMENTS

WHAT YOU NEED TO KNOW ABOUT 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.

MEDICARE PART D NOTICE

Important Notice from Your Employer 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 your employer 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. Employer has determined that the prescription drug coverage offered by our plans are, 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 through December 7th.

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

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

If you decide to join a Medicare drug plan, your current employer coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under your employer 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 current prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with your employer 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 office 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 your employer 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 www.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 or (800) 633-4227. TTY users should call (877) 486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Date:	October 1, 2023
Name of Entity:	SCCOE
Contact:	Sheri Meyers, Manager Employee Benefits
Address:	1290 Ridder Park Drive MC 264 San Jose, CA 95131
Phone:	(408) 453-6583

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in the 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 the 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 the 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.

HIPAA NOTICE OF PRIVACY PRACTICES

We maintain the HIPAA Notice of Privacy Practices describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

NOTICE OF CHOICE OF PROVIDERS

HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, your carrier will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier directly.

AVAILABILITY OF SUMMARY INFORMATION

As an employee the health benefits provided by SCCOE represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. SCCOE offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by SCCOE are available by contacting Human Resources.

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 January 31, 2022. 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: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322 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://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: Medicaid https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext. 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479 All other Medicaid
Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/hawki
Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346- 9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/

LOUISIANA – Medicaid

Website: http://www.medicaid.la.gov or http://www.ldh.la.gov/lahipp
Phone: 1-888-342-6027 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

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/oii/hipp.htm Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ 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 http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
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: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: https://www.coverva.org/hipp/ Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
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 January 31, 2020, 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

END OF RELIEF PERIOD EXTENDING CERTAIN DEADLINES IN RESPONSE TO THE COVID-19 CRISIS WILL DEPEND ON THE DATE AN INDIVIDUAL ACTION WOULD HAVE BEEN REQUIRED WITH SOME DEADLINES RESUMING FEB. 28, 2021

On April 28, 2020 Multi-Agency guidance extended certain deadlines that apply to group health plans that fall within the COVID-19 outbreak period beginning March 1, 2020. Those deadlines included and were limited to the following:

- The 30-day period to request special enrollment under HIPAA (or 60-day period as applicable to CHIP enrollment requests);
    - employees, spouses, and new dependents are allowed to enroll upon marriage, birth, adoption, or placement for adoption;
    - employees and dependents are allowed to enroll if they had declined coverage due to other health coverage and then lose eligibility or lose all employer contributions towards active coverage;
    - employees and their dependents are allowed to enroll upon loss of coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs
- The 60-day election period for COBRA continuation coverage;
- The deadline for making COBRA premium payments;
- The 60-day deadline for individuals to notify a plan of a COBRA qualifying event or determination of disability;
- The deadline for individuals to file an ERISA benefit claim under the plan's claims procedure (including a H-FSA run out period deadline that ends during the outbreak period); or
- The deadline for claimants to file an appeal of an adverse benefit determination, a request for an external review, and to file information related to a request for external review for an ERISA plan.

The period that these deadlines can be tolled is limited to one year. On Feb. 28, 2021, one year from March 1, 2020, some of the above timelines will no longer be tolled. Individual timeframes listed above that are subject to deadline relief will have the applicable deadlines disregarded only until the earlier of: (a) 1 year from the date they were first eligible for relief, or (b) 60 days after the announced end of the National Emergency (the end of the Outbreak Period). On those individualized applicable dates, the timeframes for employees/participants with periods that were previously tolled will resume.

Examples and Explanations:

- If a qualified beneficiary would have been required to make a COBRA election by March 1, 2020, the individual can wait until February 28, 2021, which is the earlier of 1 year from March 1, 2020 or the end of the Outbreak Period. Because the individual had 60 days to elect before the start of the Outbreak he or she would need to make an election by February 28, 2021.
- If a qualified beneficiary would have been required to make a COBRA election by March 1, 2021, the Notice delays that election requirement until the earlier of 1 year from that date (March 1, 2022) or the end of the Outbreak Period, with the possibility of an additional 60-day extension.
- If an individual experienced the birth of a child in February 2021 and the National Emergency was declared over July 1, 2021 **(hypothetically)**, the employee would have 60 days from the end of the National Emergency plus 30 days under HIPAA to give notice of the birth to request enrollment from the plan, September 29, 2021.

Again, if you have any questions regarding these changes to the Plan or your specific circumstances, please contact your HR administrator.

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.

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 9.61% in 2023 of your modified adjusted household income.

DETERMINING ELIGIBILITY

LOOK-BACK MEASUREMENT METHOD

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

Under the ACA, employers are required to report specific benefits information to IRS on "full-time" employees as defined by the ACA. A "full-time" employee is generally an employee whose works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. SCCOE uses the look-back measurement method to determine group health plan eligibility.

NEW EMPLOYEES HIRED TO WORK FULL-TIME: If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of the first of the month following your hire date.

NEW EMPLOYEES HIRED TO WORK A PART-TIME, VARIABLE HOUR OR SEASONAL

SCHEDULE: If you are hired into a part-time position, a position where your hours vary and SCCOE is unable to determine — as of your date of hire — whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of eleven months. Your IMP will begin as of your month of hire. If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage. Your full-time status will remain in effect during an associated stability period that will last 12 months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

ONGOING EMPLOYEES: An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the period during which SCCOE counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for 12 months. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

DETERMINING ELIGIBILITY

LOOK-BACK MEASUREMENT METHOD

SCCOE uses the standard measurement period and associated stability period annual cycle set forth below:

MEASUREMENT PERIOD: Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility.

STABILITY PERIOD: Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.

MORE INFORMATION

This notice does not fully describe continuation of coverage or other rights under the Plan. More information about continuation of coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact:

Benefits Specialist	Last name beginning	Phone	Fax	Email
Denise Sanders	A-G	(408) 453-6831	(408) 453-3660	dsanders@sccoe.org
Yuvika Singh	H-O	(408) 453-4355	(408) 453-3658	ysingh@sccoe.org
Patty Tijerina	P-Z	(408) 453-6681	(408) 453-3659	ptijerina@sccoe.org

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-888-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

1290 Ridder Park Drive MC 264
San Jose, CA 95131
(408) 453-6500