



2024 OPEN ENROLLMENT
SANTA CLARA COUNTY
SCHOOLS' INSURANCE GROUP

EMPLOYEE
BENEFITS
GUIDE



2024 OPEN ENROLLMENT

WELCOME TO THE SANTA CLARA COUNTY SCHOOLS' 2024 OPEN ENROLLMENT

You are an important part of our team at Santa Clara County Schools' Insurance Group, and we appreciate your hard work and dedication. Because you play such an important role in our success, we are pleased to provide you with the resources you need to protect and care for yourself and your family. Your benefits program offers everything you need to stay healthy—physically and financially.

We understand that your benefit needs change as your life changes. That's why we offer flexible plans that fit every state of life. We invite you to learn about your options, so you can make the most of the benefits available to you.

As you know, information is key when it's time to make important choices. In this guide, you'll find details about your benefits program. We encourage you to carefully review the plans and select the right coverage for your unique needs.

As always, we value you as a member of the Santa Clara County Schools' Insurance Group family and look forward to a healthy and safe 2023.

Eligibility

Check with your Benefits Coordinator to confirm your benefits eligibility.

You have three opportunities to enroll or make changes:

1. Within 30 days of becoming benefits eligible
2. During the annual open enrollment period
3. Within 30 days of a qualified change in family status such as:
 - a. Marriage, divorce, or legal separation
 - b. Birth or adoption of a child
 - c. Death of a dependent
 - d. Loss/Gain of other health coverage for you and/or dependents
 - e. Change in employment status
 - f. Change in Medicaid/Medicare eligibility
 - g. Receipt of a Qualified Medical Child Support Order or other court order

OPEN ENROLLMENT DEADLINE AND ASSISTANCE

Please contact your District's Benefits Coordinator for enrollment assistance and deadlines.

Eligible Dependents

- Your legal spouse or domestic partner (same sex and opposite sex as defined by the State of California)
- Your natural, adopted, or stepchildren up to age 26
- Your dependent children of any age, if disabled and incapable of self-support due to mental or physical disability (child must be disabled prior to reaching age 26).

Proof of dependent status may be required to enroll such as:

- birth certificate
- tax documents
- marriage certificate/proof of domestic partnership.

Domestic Partnership Info: [Frequently Asked Questions :: California Secretary of State](#)

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CONTACT INFORMATION

If you have any questions regarding your benefits, please contact one of the carriers listed below or your HR Representative.

MEDICAL INSURANCE

Kaiser, Group No. 38160

www.kp.org

(800) 464-4000 (English)

(800) 788-0616 (Spanish)

UHC, Group No. 918667

www.myuhc.com

(800) 624-8822

HEALTH SAVINGS ACCOUNT (HSA)

Optum Bank

www.optumbank.com

(866) 234-8913

DENTAL INSURANCE

Delta Dental, Group No. 07102

www.deltadentalins.com

(866) 499-3001

VISION INSURANCE

VSP, Group No. 30079708

www.vsp.com

(800) 877-7195

EMPLOYEE WELLBEING SOLUTIONS (EWS)

Optum Liveandworkwell (Access code: sccsig)

www.liveandworkwell.com

(866) 374-6061



Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.



MEDICAL INSURANCE

HOW TO GET STARTED

1. SELECT YOUR MEDICAL PLAN

- 3 KAISER HMOS
- 6 UHC HMOS
- 1 UHC HSA PPO

THINGS YOU SHOULD KNOW ABOUT AN HMO:

- You must live or work within the HMO service area
- You and your covered dependents will need to select a Primary Care Physician (PCP)
- Your PCP must refer you to Specialists/other Providers. You cannot self-refer

THE UHC HSA PPO PLAN MAY BE FOR YOU IF THE FOLLOWING IS TRUE:

- You are interested in establishing a Health Savings Account
- You want the option to see providers in or out-of-network. *Keep in mind that you save by seeing in-network providers*
- Catastrophic coverage
- You have more control over your health care dollars

YOUR HEALTH PLAN OPTIONS

At Santa Clara County Schools' Insurance Group, we understand that balancing work, life, finances, relationships and health can be overwhelming. We've made it a priority to help you achieve that balance, so you can live the healthiest life possible. That's why we designed our benefits package to meet these needs. We hope you take advantage of the wonderful health and wellness programs available to you.

Nothing is more important than your health. Our goal is to help you be the best version of you. Choosing the right plan to meet your needs is the first step to living a healthy life.

When deciding which medical plan is the best fit for you and your family, it's important to consider the total cost of coverage. This includes what you pay in premiums out of your paycheck and what you pay for services. While each medical plan covers preventive screenings in full, the medical plans vary on annual deductibles, copays, and levels of coinsurance. This means you may pay more out-of-pocket costs with one plan versus another. The ideal medical plan should cover most of your health plan with out-of-pocket costs that meet your budget.

WELLNESS

The Santa Clara County Schools' Insurance Group offers a robust Wellness program to its members. Please check with your school district for various wellness events and activities taking place throughout the year.



MEDICAL INSURANCE

Your Medical Plan Options

Health Maintenance Organization (HMO) Plan

With an HMO plan, you select a Primary Care Physician (PCP) who will coordinate your health care needs, including referrals to specialists. You typically pay a flat dollar amount (copay) for qualified health care services. The HMO plan offers in-network coverage only. If you visit a provider outside of the plan's network, you will be responsible for the full cost of services.

Within the UHC plans, two HMO networks UHC SignatureValue HMO and UHC SignatureValue Harmony HMO will be available to give you the flexibility to choose the right coverage network for you and your family.

SignatureValue is the full network that includes Sutter while SignatureValue Harmony is UHC's alliance with Canopy Health network which offers the same great coverage as the traditional full HMO plans but with lower premiums. The primary difference is the network - in this instance, Canopy Health. Canopy Health network includes 5,000 providers working at 23 hospitals and 5 medical groups across 9 Bay Area counties. Members who elect the SignatureValue Harmony plan will also have referral access to more than 3,000 specialists within the Canopy Health Alliance. Visit <https://whyuhc-stage.uhc.com/svharmonynocal> to learn more.

To change your PCP you must call UHC between the 1st and 15th of the month in order for the change to become effective the 1st of the following month, i.e. to change your PCP as of March 1st, you must call UHC between February 1st and 15th. If you call between February 16th and 28th, the change will become effective April 1st.

High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

With the HDHP, you can receive medical services from Select Plus Network which offers both in-network or out-of-network providers. You pay for all medical services until you reach the annual deductible, except for in-network preventive care which is covered in full. After your annual deductible is met, the plan pays for a percentage of covered services known as coinsurance. When you reach the out-of-pocket maximum, the plan will pay 100% for all eligible expenses for the remainder of the calendar year.

When you enroll in the HDHP, you are eligible to open a Health Savings Account (HSA) to help pay for eligible health care expenses (deductibles, coinsurance, and prescriptions) with pre-tax dollars. See the How the Health Savings Account (HSA) Works section in this guide for more information.

Find a UHC Provider

1. Log on to: www.myuhc.com
2. Select "Find a Provider"
3. Select "Medical Directory"
4. Select "All UHC Plans"
5. Select "SignatureValue Plans for HMO" or "Select Plus for PPO"
6. Select "Medical Directory"
7. Select "California"
8. Select either "SignatureValue HMO" or "SignatureValue Harmony HMO"
9. Enter your search criteria

Find a Kaiser Provider

1. Log on to: www.kp.org
2. Select "Doctors & Locations"
3. Select Location
4. Enter your search criteria

CARE OPTIONS & WHEN TO USE THEM

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.kp.org or www.myuhc.com.



PRIMARY CARE

- Routine, primary/preventive care
 - Non-urgent treatment
 - Chronic disease management
- For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.



URGENT CARE

- Sprains
 - Small cuts
 - Strains
 - Minor infections
 - Sore throats
 - Mild asthma attacks
 - Back pain or strains
- Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours – or if you can't be seen by your doctor immediately – you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.



EMERGENCY ROOM

- Heavy bleeding
 - Large open wounds
 - Chest pain
 - Spinal injuries
 - Difficulty breathing
 - Major burns
 - Severe head injuries
- An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.



TELEHEALTH

- Cold/flu
 - Diarrhea
 - Fever
 - Rash
 - Sinus problems
- Retail Telehealth, or a "virtual visit," lets you talk to a doctor anytime, anywhere from your mobile device or computer – no appointment necessary. Kaiser and UHC offer telehealth to bring you care from the comfort and convenience of your home or wherever you are. See page 10 for more information.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call **9-1-1**, even if your symptoms are not described here.

▶ Primary Care vs. Urgent Care vs. ER

MEDICAL INSURANCE

Kaiser	Kaiser Deductible HMO Low Plan	Kaiser Deductible HMO Mid Plan	Kaiser Traditional HMO High Plan
	In-Network Only	In-Network Only	In-Network Only
Deductible Individual / Family	\$3,000 / \$6,000	\$500 / \$1,000	None
Calendar Year Out-of-Pocket Maximum Individual / Family	\$6,000 / \$12,000	\$3,000 / \$6,000	\$1,500 / \$3,000
Lifetime Maximum Individual / Family	Unlimited	Unlimited	Unlimited
Office Visits Preventative Care Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care	Covered at 100% \$40 Copay \$10 Copay \$40 Copay	Covered at 100% \$20 Copay \$10 Copay \$20 Copay	Covered at 100% \$20 Copay No Charge \$20 Copay
Hospital Visits Inpatient Care Outpatient Surgery Emergency Room (copay waived if admitted)	Deductible, then 30% Deductible, then 30% Deductible, then 30%	Deductible, then 10% Deductible, then 10% Deductible, then 10%	\$500 Copay \$20 Copay \$125 Copay
Chiropractic	Refer to your SBC	Refer to your SBC	Refer to your SBC
Acupuncture	Not Covered	Not Covered	Not Covered
Prescription Drug - Retail Generic Brand Preferred Most Specialty	(30-day supply) \$10 Copay \$30 Copay \$35 Copay	(30-day supply) \$10 Copay \$30 Copay \$35 Copay	(100-day supply except for Specialty, 30-day supply) \$10 Copay \$25 Copay \$35 Copay
Prescription Drug - Mail Order Generic Brand Preferred Most Specialty	(up to 100-day supply) \$20 Copay \$60 Copay N/A	(up to 100-day supply) \$20 Copay \$60 Copay N/A	(up to 100-day supply) \$10 Copay \$25 Copay N/A

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

All plans are detailed in Kaiser's Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

IMPORTANT: To see how Kaiser is handling testing, inpatient hospital admissions (including treatment), telehealth visits, etc. as a result of COVID-19 visit their website here:

<https://healthy.kaiserpermanente.org/health-wellness/coronavirus-information>

MEDICAL INSURANCE

UnitedHealthcare	UHC HMO Low Plan	UHC HMO Mid Plan	UHC HMO High Plan
	In-Network Only	In-Network Only	In-Network Only
Deductible Individual / Family	\$500 / \$1,000	\$250 / \$500	None
Calendar Year Out-of-Pocket Maximum Individual / Family	\$5,000 / \$10,000	\$2,500 / \$5,000	\$1,500 / \$3,000
Lifetime Maximum Individual / Family	Unlimited	Unlimited	Unlimited
Office Visits Preventative Care Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care	Covered at 100% \$40 Copay No Charge \$40 Copay	Covered at 100% \$30 Copay No Charge \$30 Copay	Covered at 100% \$30 Copay No Charge \$30 Copay
Hospital Visits Inpatient Care Outpatient Surgery Emergency Room (copay waived if admitted)	Deductible, then 30% Deductible, then 30% \$250 Copay	Deductible, then 10% Deductible, then 10% \$150 Copay	\$750 Per Admission No Charge \$150 Copay
Chiropractic (40 visits/year combined)	\$15 Copay	\$15 Copay	\$15 Copay
Acupuncture (40 visits/year combined)	\$15 Copay	\$15 Copay	\$15 Copay
Prescription Drug - Retail (up to 30-day supply)			
Generic	\$10 Copay	\$10 Copay	\$10 Copay
Brand Preferred	\$30 Copay	\$30 Copay	\$25 Copay
Brand Non-preferred	\$50 Copay	\$50 Copay	\$40 Copay
Prescription Drug - Mail Order (up to 90-day supply)			
Generic	\$10 Copay	\$10 Copay	\$10 Copay
Brand Preferred	\$60 Copay	\$60 Copay	\$50 Copay
Brand Non-preferred	\$100 Copay	\$100 Copay	\$80 Copay

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

All plans are detailed in UHC's Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

IMPORTANT: To find COVID-19 vaccine resources in your area, visit <https://covid19vaccinecenterlocator.uhc.com/cvcl>

MEDICAL INSURANCE

UnitedHealthcare	UHC PPO HSA	
	In-Network	Out-of-Network
Deductible Individual / Family	\$2,800 / \$5,600	\$3,000 / \$6,000
Calendar Year Out-of-Pocket Maximum Individual / Family	\$2,800 / \$5,600	\$7,000 / \$14,000
Lifetime Maximum Individual / Family	Unlimited	Unlimited
Office Visits Preventative Care Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care	Covered at 100% Deductible, then 0% Deductible, then 0% Deductible, then 0%	Not Covered Deductible, then 30% Deductible, then 30% Deductible, then 30%
Hospital Visits Inpatient Care Outpatient Surgery Emergency Room (copay waived if admitted)	Deductible, then 0% Deductible, then 0% Deductible, then 0%	Deductible, then 30% Deductible, then 30% Deductible, then 0%
Chiropractic (24 visits/year combined)	Deductible, then 0%	Deductible, then 30%
Acupuncture (12 visits/year combined)	Deductible, then 0%	Deductible, then 30%
Prescription Drug - Retail (up to 31-day supply) Generic Brand Preferred Brand Non-preferred	Deductible, then \$10 Copay Deductible, then \$30 Copay Deductible, then \$50 Copay	Deductible, then \$10 Copay Deductible, then \$30 Copay Deductible, then \$50 Copay
Prescription Drug - Mail Order (up to 90-day supply) Generic Brand Preferred Brand Non-preferred	Deductible, then \$20 Copay Deductible, then \$60 Copay Deductible, then \$100 Copay	Not Covered

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

All plans are detailed in UHC's Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

IMPORTANT: To find COVID-19 vaccine resources in your area, visit <https://covid19vaccinecenterlocator.uhc.com/cvcl>.

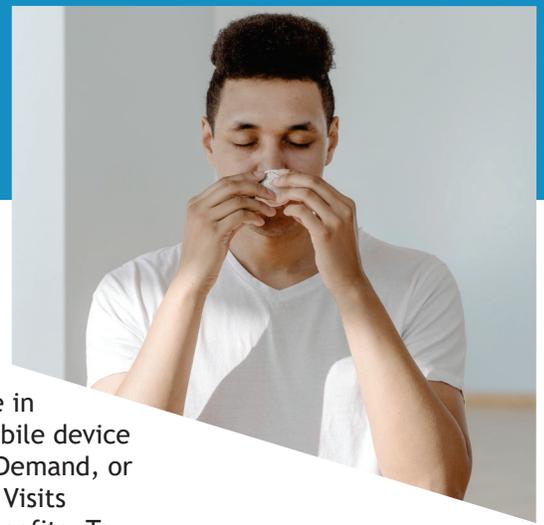
TELEHEALTH



VIRTUAL VISIT WITH UNITEDHEALTHCARE

Amwell, Doctor On Demand, Teladoc

See a doctor whenever, wherever. Get 24/7 access to care from anywhere in the US with Virtual Visits. A Virtual Visit lets you see a doctor from your mobile device or computer without an appointment. Choose from an Amwell, Doctor On Demand, or Teladoc network provider and pay \$50 or less for the visit. All three Virtual Visits provider networks are covered under your UnitedHealthcare health plan benefits. To learn more or to start a Virtual Visit, go to uhc.com/virtualvisits or myuhc.com.



TIPS FOR REGISTERING:

- 1 For VirtualVisits, access or to find out more, download the Amwell, Doctor On Demand, or Teladoc mobile apps today.
- 2 Locate your member ID number on your health plan ID card.
- 3 Have your credit card ready to cover any costs not covered by your health plan.
- 4 Choose a pharmacy that's open in case you're given a prescription.



KAISER PERMANENTE ENROLLEES - GET CARE FROM THE COMFORT OF HOME

- **E-visit** - Fill out a short questionnaire about your symptoms online and get personalized self care advice from a Kaiser Permanente clinician.
- **Phone appointment** - Schedule an appointment to talk with a Kaiser Permanente clinician over the phone, just like an in-person visit..
- **Email** - Message your doctor's office with nonurgent questions anytime through your kp.org account
- **Video visit** - Meet face to face with a doctor by video for the same high-quality care as an in-person visit
- **Mail-order pharmacy** - Get prescriptions sent straight to your door with our mail-order delivery service.

READY TO MAKE AN APPOINTMENT?

Go online: Sign into kp.org or use the Kaiser Permanente app. If you're a member in Colorado or Washington, you can also chat online with a doctor through your kp.org account.

Call 24/7 using one of the following numbers:

California

Northern California: (650) 358-7015
Southern California: (833) 574-2273

Colorado

Denver/Boulder: (303) 338-4545
Mountain/Northern CO: (970) 207-7171
Southern CO: (800) 218-1059

Georgia

(404) 365-0966

Hawaii

Oahu: (808) 432-2000
Maui: (808) 243-6000
Hawaii Island: (808) 334-4400
Kauai: (808) 246-5600

Maryland/Virginia/Washington, DC
(800) 777-7904

Oregon/SW Washington

Portland: (503) 813-2000
All other areas: (800) 813-2000

Washington

(800) 297-6877

HEALTH SAVINGS ACCOUNT (HSA)



UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

THERE ARE TWO WAYS YOU CAN PUT MONEY INTO YOUR HSA:

- Regular payroll deductions on a pre-tax basis, and
- Lump-sum contributions of any amount, anytime, up to the maximum limit.

WHAT IS AN HSA?

A savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents. Once money goes into the account, it's yours to keep – the HSA is owned by you, just like a personal checking or savings account.

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds – or all three). Of course, your funds are always available if you need them for qualified health care expenses.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money always belongs to you, even if you leave the company, and unused funds carry over from year to year. You never have to worry about losing your money. That means if you don't use a lot of health care services now, your HSA funds will be there if you need them in the future – even after retirement.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

You can use your HSA for your spouse and tax dependents for their eligible expenses – even if they're not covered by your medical plan.

▶ What Is A Health Savings Account?

Contribute up to \$4,150 Single, or \$8,300 Family

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or TRICARE due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2024 are \$4,150 for Single and \$8,300 for Family coverage. If you're age 55 or older, you are allowed to make an extra \$1,000 contribution each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications (such as allergy medicine, cold and flu, pain relievers, and feminine hygiene)
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. But save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

HEALTH SAVINGS ACCOUNT (HSA)

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications (such as allergy medicine, cold and flu, pain relievers, and feminine hygiene)
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at [irs.gov](https://www.irs.gov).

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

THIS MAY BE THE BEST PLAN OPTION FOR YOU IF ANY OF THE FOLLOWING IS TRUE:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax income to a Health Savings Account.

FREQUENTLY ASKED QUESTIONS

WHAT WILL I PAY AT THE PHARMACY WITH THE HSA QUALIFIED PLAN OPTIONS?

You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

WHAT WILL I PAY AT THE PHYSICIAN'S OFFICE WITH THE HSA QUALIFIED PLAN?

You'll provide your ID card at the time of the visit and the physician's office will submit the claim to UnitedHealthcare.

You will not owe anything at the time of the visit. Later you'll receive an Explanation of Benefits (EOB) from UnitedHealthcare that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

WHERE CAN I GET A COPY OF AN EOB?

You can access all of your EOB information, as well as obtain other important information, by logging into www.myuhc.com.

DENTAL INSURANCE

2. REVIEW YOUR DENTAL PLAN



DELTA DENTAL IS THE DENTAL CARRIER FOR 2024.

Good dental care is an important part of your overall health. Our dental plans through Delta Dental help you keep your smile healthy through regular preventive dental care and offers coverage to fix problems as soon as they occur.

With the PPO dental plan, you may visit any dentist of your choice. Keep in mind, you'll receive the highest coverage when you use an in-network provider. If you visit an out-of-network provider, you will not benefit from discounted rates and will pay more out-of-pocket for services.

In this incentive plan, Delta Dental pays 70% of the contract allowance for covered diagnostic, preventive and basic services and 70% of the contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

DENTAL INSURANCE PLAN OPTIONS

Delta Dental	Delta Dental Low Plan		Delta Dental High Plan		Delta Dental Premium Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:
Calendar Year Deductible Individual / Family	None	None	None	None	None	None
Calendar-Year Benefit Maximum Paid by Delta D&P Maximum Waiver incl.	\$1,200	\$1,000	\$2,200	\$2,000	\$3,200	\$3,000
Diagnostic / Preventive Services (e.g., x-rays, cleanings, exams)	0% - 30%	0% - 30%	0% - 30%	0% - 30%	0% - 30%	0% - 30%
Basic and Major Services (e.g., fillings, sealants, crowns, inlays, onlays and cast restorations)	0% - 30%	0% - 30%	0% - 30%	0% - 30%	0% - 30%	0% - 30%
Prostodontics (e.g., dentures and bridges)	50%	50%	50%	50%	50%	50%
Implants	N/A	N/A	N/A	N/A	50%	50%
Occlusal Guards	50% to \$500 lifetime max.	50% to \$500 lifetime max.	50% to \$500 lifetime max.	50% to \$500 lifetime max.	50% to \$500 lifetime max.	50% to \$500 lifetime max.
Orthodontia Services	N/A		0% \$2,000 lifetime maximum paid by Delta (child only)		0% \$3,000 lifetime maximum paid by Delta (adult and child)	

What Is Dental Insurance?

To find an in-network provider, visit www.deltadentalins.com.



VSP IS THE VISION CARRIER FOR 2024.

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. To find a participating provider, go to www.vsp.com.

VISION INSURANCE PLAN OPTIONS

VSP	VSP Low Plan		VSP High Plan		VSP Premium Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Examination	\$25 Copay	<u>Reimbursement:</u> Up to \$45	\$15 Copay	<u>Reimbursement:</u> Up to \$45	\$5 Copay	<u>Reimbursement:</u> Up to \$45
Frequency of Service Exam Lenses Frames Elective Contact Lenses	Every 12 months Every 24 months Every 24 months Every 24 months		Every 12 months Every 12 months Every 24 months Every 12 months		Every 12 months Every 12 months Every 12 months Every 12 months	
Lenses Single Bifocal Trifocal	Covered in Full Covered in Full Covered in Full	<u>Reimbursement:</u> Up to \$45 Up to \$65 Up to \$85	Covered in Full Covered in Full Covered in Full	<u>Reimbursement:</u> Up to \$45 Up to \$65 Up to \$85	Covered in Full Covered in Full Covered in Full	<u>Reimbursement:</u> Up to \$45 Up to \$65 Up to \$85
Frames	<u>Allowance:</u> Up to \$150	<u>Reimbursement:</u> Up to \$47	<u>Allowance:</u> Up to \$170	<u>Reimbursement:</u> Up to \$47	<u>Allowance:</u> Up to \$200	<u>Reimbursement:</u> Up to \$47
Elective Contact Lenses (in lieu of lenses and frames)	Up to \$60 Copay for contact lens exam (fitting/evaluation) <u>Allowance:</u> Up to \$150	<u>Reimbursement:</u> Up to \$105	Up to \$60 Copay for contact lens exam (fitting/evaluation) <u>Allowance:</u> Up to \$170	<u>Reimbursement:</u> Up to \$105	Up to \$60 Copay for contact lens exam (fitting/evaluation) <u>Allowance:</u> Up to \$200	<u>Reimbursement:</u> Up to \$105
LightCare	\$150 allowance for non-prescription sunglasses or non-prescription blue light filtering glasses instead of prescription glasses or contacts		\$170 allowance for non-prescription sunglasses or non-prescription blue light filtering glasses instead of prescription glasses or contacts		\$200 allowance for non-prescription sunglasses or non-prescription blue light filtering glasses instead of prescription glasses or contacts	



What Is Vision Insurance?

EMPLOYEE WELLBEING SOLUTIONS (EWS)

As part of your benefits, Optum EAP and WorkLife services are available at no extra cost to you. This includes referrals, seeing in-network clinicians, access to liveandworkwell.com and initial consultations with mediators or financial and legal experts. If you want to retain a lawyer after your consultation, you'll get a 25% discount.

From listening to your child talk about being bullied to witnessing a traumatic event, secondhand stress can affect you too. If you're finding it hard to stay positive when tough things happen to others, your EAP and WorkLife Services Benefit offers confidential support for managing:

- Anxiety and depression
- Parenting and family issues
- Relationship problems
- Workplace changes
- Living with chronic conditions
- Substance use
- Child and eldercare support

[LIVEANDWORKWELL.COM](https://liveandworkwell.com)

This interactive website offers tools and resources to help you enhance your work, health and life. On the site, you can:

- Check your benefit information
- Submit online service requests
- Search the online clinician directory
- Use virtual help centers to find information and resources for hundreds of everyday work and life issues
- Access financial calculators, legal articles and other tools
- Search databases for childcare, nursing homes and other local resources
- Participate in interactive, customizable self-improvement programs

Any member of your household can use liveandworkwell.com, even children living away from home.

All records are kept confidential in accordance with federal and state laws. Your personal records will never be shared with your employer or anyone else without your permission.

Call (866) 374-6061 or log onto www.liveandworkwell.com and use Access Code **sccsig**.

[▶ Making the Most of Your EAP](#)



EMPLOYEE WELLBEING SOLUTIONS (EWS)

5

**No cost Face-to-Face or
Virtual Visits per problem
per year**

Call: 866-374-6061

Visit: liveandworkwell.com



Self Care by AbleTo

This is on-demand self-guided help for stress and emotional well-being, included at no extra cost, available via a mobile app or online, 24/7.

- Navigate to LiveandWorkWell.com
- Register your HealthSafelD or browse as a guest with Company Code SCCSIG.
- Look for Self Care from AbleTo on your home page
- Go to iOS / Google Play store to download the Self Care app
- Log into app using registration information



TALKSPACE

Another option to communicate with a licensed, master-level or higher EAP provider via text, voice or video message from your smartphone or desktop.

- Contact EAP to obtain Authorization
- Go to Talkspace on employer's specific landing page on LiveandWorkWell.com to get started
- Accessible via desktop or the app
- App downloadable via the App Store and Google Play



VIDEO RESOURCES

MEDICAL PLANS

▶ [Primary Care vs. Urgent Care vs. ER](#)

▶ [HMO Overview](#)

▶ [PPO Overview](#)

▶ [HDHP vs. PPO](#)

▶ [HDHP With HSA Overview](#)

▶ [Why Choose Kaiser Permanente](#)

INSURANCE 101

▶ [Benefits Key Terms Explained](#)

▶ [How To Read An EOB](#)

▶ [What Is A Qualifying Event?](#)

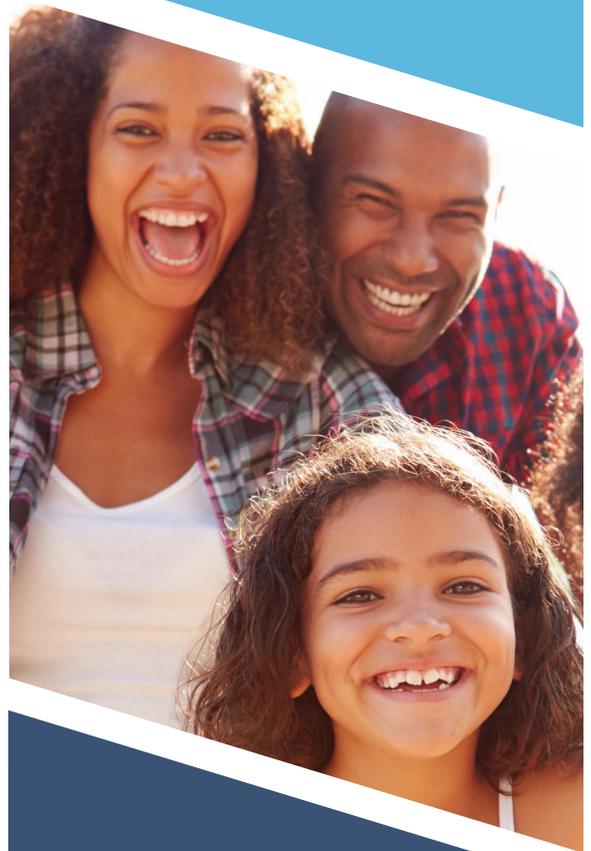
TAX ADVANTAGE SAVINGS ACCOUNTS

▶ [What Is A Health Savings Account?](#)

ANCILLARY BENEFITS

▶ [What Is Dental Insurance?](#)

▶ [What Is Vision Insurance?](#)



GLOSSARY OF MEDICAL TERMS

INSURANCE TERMS

-  **Coinsurance**—The plan’s share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.
-  **Copays**—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.
-  **Deductible**—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.
-  **Lifetime Benefit Maximum**—All plans are required to have an unlimited lifetime maximum.
-  **Network Provider**—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider’s normal fees for services.
-  **Out-of-pocket Maximum**—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.
-  **Preauthorization**—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.
-  **UCR (Usual, Customary and Reasonable)**—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

-  **Prescription Drugs**—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.
-  **Urgent Care**—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.
-  **Emergency Room**—Services you receive from a hospital for any serious condition requiring immediate care.
-  **Preventive Services**—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.
-  **Medically Necessary**—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from SCCSIG 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 SCCSIG 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. SCCSIG has determined that the prescription drug coverage offered by the Kaiser and UnitedHealthCare health plans 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 current SCCSIG coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the SCCSIG medical plan, **be aware that you and your dependents may not be able to get this coverage back.**

IMPORTANT NOTICES

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 SCCSIG 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 your District's Benefits Coordinator 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 SCCSIG 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 1-800-772-1213 (TTY 1-800-325-0778).

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: 01/01/2024
Name of Entity/Sender: Santa Clara County Schools' Insurance Group
Contact--Position/Office: District Human Resources Department

IMPORTANT NOTICES

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, 2023. Contact your State for more information on eligibility -

ALABAMA - Medicaid	ALASKA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	CALIFORNIA - Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	FLORIDA - Medicaid
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	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

IMPORTANT NOTICES

GEORGIA - Medicaid	INDIANA - Medicaid
<p>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</p>	<p>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</p>
IOWA - Medicaid and CHIP (Hawki)	KANSAS - Medicaid
<p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki 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</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY - Medicaid	LOUISIANA - Medicaid
<p>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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE - Medicaid	MASSACHUSETTS - Medicaid and CHIP
<p>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: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA - Medicaid	MISSOURI - Medicaid
<p>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</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA - Medicaid	NEBRASKA - Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

IMPORTANT NOTICES

NEVADA - Medicaid	NEW HAMPSHIRE - Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 5218
NEW JERSEY - Medicaid and CHIP	NEW YORK - Medicaid
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid	NORTH DAKOTA - Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP	OREGON - Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA - Medicaid and CHIP	RHODE ISLAND - Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA - Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - Medicaid	UTAH - Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT- Medicaid	VIRGINIA - Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON - Medicaid	WEST VIRGINIA - Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP	WYOMING - Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

IMPORTANT NOTICES

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

IMPORTANT NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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.
- Prosthesis.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

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 District's Benefits Coordinator.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether he/she was covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2023. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although SCCSIG may use aggregate information it collects to design a program based on identified health risks in the workplace, the health plan will never disclose any of your personal health information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may

IMPORTANT NOTICES

never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are health professionals in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your District's Benefits Coordinator.

INITIAL COBRA NOTICE *[FOR NEW HIRES OR NEW BENEFITS ELIGIBLE ONLY]*

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what**

you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

IMPORTANT NOTICES

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your District's Human Resources Department.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second

IMPORTANT NOTICES

qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement,

even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Contact your District's Human Resources Department

This notice is a summary. For a full description of all of SCCSIG's benefit plans, please refer to HR for more information.



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The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.

Santa Clara County Schools' Insurance Group 2024 Medical Plans



	KAISER PERMANENTE PLANS			UHC PLANS				
	Traditional HMO HIGH PLAN	Deductible HMO MID PLAN	Deductible HMO LOW PLAN	Traditional HMO HIGH PLAN	Deductible HMO MID PLAN	Deductible HMO LOW PLAN	High Deductible PPO HSA PPO HSA PLAN	
Plan Details	<i>Kaiser HMO Plan Providers</i>			<i>UHC SignatureValue (Full Network) and UHC SignatureValue Harmony (Limited Network) HMO Providers</i>				
Annual Deductible (Ind/Fam)	None	\$500/\$1,000	\$3,000/\$6,000	None	\$250/\$500	\$500/\$1,000	\$2,800/\$5,600	\$3,000/\$6,000
Out of Pocket Max (Ind/Fam)	\$1,500/\$3,000	\$3,000/\$6,000	\$6,000/\$12,000	\$1,500/\$3,000	\$2,500/\$5,000	\$5,000/\$10,000	\$2,800/\$5,600	\$7,000/\$14,000
Benefit Details	<i>Kaiser HMO Plan Providers</i>			<i>UHC SignatureValue (Full Network) and UHC SignatureValue Harmony (Limited Network) HMO Providers</i>				
Preventive Care	\$0	\$0 (ded waived)	\$0 (ded waived)	\$0	\$0 (ded waived)	\$0 (ded waived)	\$0 (ded waived)	Not Covered
Office Visit	\$20 Copay	\$20 Copay (ded waived)	\$40 Copay (ded waived)	\$30 Copay	\$30 Copay (ded waived)\$0	\$40 Copay (ded waived)\$0	\$0 (after ded)	30% (after ded)
Diagnostic Lab & Xray	\$0	\$10 Copay (ded waived)	\$10 Copay (ded waived)	\$0	10% (after ded)	10% (after ded)	\$0 (after ded)	30% (after ded)
Inpatient Hospital	\$500/admit	10% (after ded)	30% (after ded)	\$750/admit	10% (after ded)	30% (after ded)	\$0 (after ded)	30% (after ded)
Outpatient Surgery	\$20 Copay	10% (after ded)	30% (after ded)	\$0	\$30 Copay (ded waived)	\$40 Copay (ded waived)	\$0 (after ded)	30% (after ded)
Outpatient Rehab Therapy	\$20 Copay	\$20 Copay (ded waived)	\$40 Copay (ded waived)	\$30 Copay	10% (after ded)	30% (after ded)	\$0 (after ded)	30% (after ded)
Durable Medical Equipment	\$20 Copay	\$20 Copay (ded waived)	\$40 Copay (ded waived)	\$30 Copay	\$30 Copay (ded waived) ⁹	\$40 Copay (ded waived) ⁹	\$0 (after ded) ¹¹	30% (after ded) ¹¹
Home Health Care	20%	20% (ded waived)	20% (ded waived)	\$0	\$150 Copay (ded waived) ¹	\$250 Copay (ded waived) ¹	\$0 (after ded) ^{12,13}	30% (after ded) ^{12,13}
Emergency Room Ambulance	\$0 ⁵	\$0 (ded waived) ⁵	\$0 (ded waived) ⁵	\$30 Copay ⁸	10% (after ded)	20% (after ded)	\$0 (after ded) ¹⁴	30% (after ded) ¹⁴
Mental Health Outpatient	\$125 Copay ¹	10% (after ded)	30% (after ded)	\$150 Copay ¹	\$30 Copay (ded waived)	\$40 Copay (ded waived)	\$0 (after ded)	
Mental Health Inpatient					10% (after ded)	30% (after ded)		
Acupuncture	\$75	\$150 (ded waived)	\$150 (ded waived)	\$0	\$15 Copay ¹⁰	\$15 Copay ¹⁰	\$0 (after ded)	30% (after ded) ¹⁵
Chiropractic	\$20 Copay	\$20 Copay (ded waived)	\$40 Copay (ded waived)	\$30 Copay	\$15 Copay ¹⁰	\$15 Copay ¹⁰	\$0 (after ded)	30% (after ded)
	\$500/admit	10% (after ded)	30% (after ded)	\$600/admit			\$0 (after ded)	30% (after ded)
	Not Covered	Not Covered	Not Covered	\$15 Copay ¹⁰			\$0 (after ded) ¹⁶	30% (after ded) ¹⁶
	\$10 Copay ²	\$10 Copay (ded waived) ²	\$10 Copay (ded waived) ²	\$15 Copay ¹⁰			\$0 (after ded) ¹⁷	30% (after ded) ¹⁷
Prescription Drugs - Retail	<i>Kaiser HMO Plan Providers</i>			<i>UHC SignatureValue (Full Network) and UHC SignatureValue Harmony (Limited Network) HMO Providers</i>				
Generic	\$10	\$10	\$10	\$10	\$10	\$10	\$10 (after ded)	\$10 (after ded)
Formulary Brand	\$25	\$30	\$30	\$25	\$30	\$30	\$30 (after ded)	\$30 (after ded)
Non-Formulary Brand	In accord with Kaiser	In accord with Kaiser	In accord with Kaiser	\$40	\$50	\$50	\$50 (after ded)	\$50 (after ded)
Retail Supply	100-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply
Prescription Drugs - Mail Order	<i>Kaiser HMO Plan Providers</i>			<i>UHC SignatureValue (Full Network) and UHC SignatureValue Harmony (Limited Network) HMO Providers</i>				
Generic	\$10	\$20	\$20	\$10	\$10	\$10	\$20 (after ded)	Not Covered
Formulary Brand	\$25	\$60	\$60	\$50	\$60	\$60	\$60 (after ded)	Not Covered
Non-Formulary Brand	In accord with Kaiser	In accord with Kaiser	In accord with Kaiser	\$80	\$100	\$100	\$100 (after ded)	Not Covered
Mail Order Supply	100-day supply	100-day supply	100-day supply	90-day supply	90-day supply	90-day supply	90-day supply	Not Covered

¹ Emergency copay waived if admitted to the hospital.

² Only applicable if districts have elected Chiropractic/Acupuncture Benefit Rider. Chiro limited to 20 visits/calendar year.

³ Outpatient hospital benefit limited to \$350/admit when accessing care from a non-participating provider.

⁴ Physical therapy, physical medicine & occupational therapy, including chiropractic services limited to 24 visits per calendar year.

⁵ Up to 100 home health care visits per accumulation period

⁸ Home Health Care limited to 100 visits/calendar year; for infusion therapy, a separate \$40 per medication copay applies per 30 days⁹

Home Health Care limited to 100 visits/calendar year; for infusion therapy, a separate \$50 per medication copay applies per 30 days¹⁰

Limited to 40 visits combined for chiropractic and acupuncture

¹¹ Physical therapy, speech therapy & occupational therapy, including chiropractic services limited to 24 visits per calendar year.

¹² Limited to a single purchase of a type of durable medical equipment every three years

¹³ Prior Authorization required for Durable Medical Equipment that costs more than \$1,000

¹⁴ Home Health Care limited to 100 visits/calendar year

¹⁵ Coinsurance is only payable for non-emergency ambulance services

¹⁶ Acupuncture limited to 12 visits

¹⁷ Chiropractic limited to 24 visits