

2027 Benefits Guide

Your guide to physical,
financial & personal
wellbeing support.

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 24-25 for more details.

BENEFITS OVERVIEW

WELCOME! SANTA CLARA COUNTY SCHOOLS' INSURANCE GROUP IS PROUD TO SHARE YOUR 2027 BENEFITS PROGRAM.

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 2027.

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).
 - tax documents
 - marriage certificate/proof of domestic partnership.
 - birth certificate
- Proof of dependent status may be required to enroll such as:
 - Domestic Partnership Info: [Frequently Asked Questions :: California Secretary of State](#)

OPEN ENROLLMENT DEADLINE AND ASSISTANCE

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

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.

Note: You must make changes within 30 days of the qualifying event; if you miss that window, you will have to wait until the next Open Enrollment.

Contact Information

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

Benefit	Administrator	Phone	Group #	Website/Email
Medical	Kaiser	800.464.4000 (English) 800.788.0616 (Spanish)	Group No. 38160	www.kp.org
	UHC	800.624.8822	Group No. 918667	www.myuhc.com
Health Savings Account (HSA)	Optum Bank	866.234.8913	N/A	www.optumbank.com
Dental	Delta Dental	866.499.3001	No. 07102	www.deltadentalins.com
Dental Indemnity Plan	Personify Health	800.442.7247	Group No. P20	mycareHC.com
Vision	VSP	800.877.7195	Group No. 30079708	www.vsp.com
Employee Wellbeing Solutions (EWS)	Optum Liveandworkwell (Access code: sccsig)	866.374.6061	N/A	www.liveandworkwell.com



PHYSICAL HEALTH

Medical Benefits

Administered by Kaiser/UHC

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 HR Representative if you are eligible to participate in the various wellness activities taking place throughout the year.



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 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 Alliance HMO will be available to give you the flexibility to choose the right coverage network for you and your family.

SignatureValue is the full, broad network while SignatureValue Alliance is UHC's narrower, performance-based network. The primary difference is the network. SignatureValue includes contracted providers, providing members with a wider selection of physicians and facilities. SignatureValue Alliance is designed to help simplify your health care experience, connect you to quality care and deliver lower costs.

Please refer to the flyer on pages 10 and 11 for more details on how to find care.

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 **"Employer and Individual 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 Alliance HMO"**
9. Enter your search criteria

Find a Kaiser Provider

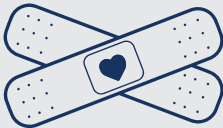
1. Log on to: www.kp.org
2. Select **"Doctors & Locations"**
3. Select Location
4. Enter your search criteria



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.myuhc2026.

	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.

Medical Insurance Plans

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	\$1,000 / \$2,000	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	Covered at 100%	Covered at 100%	Covered at 100%
Primary Care Physician / Specialist	\$40 Copay	\$20 Copay	\$20 Copay
Diagnostic Lab / X-Ray	\$10 Copay	\$10 Copay	No Charge
Urgent Care	\$40 Copay	\$20 Copay	\$20 Copay
Hospital Visits			
Inpatient Care	Deductible, then 30%	Deductible, then 20%	No Charge
Outpatient Surgery	Deductible, then 30%	Deductible, then 20%	\$20 Copay
Emergency Room (copay waived if admitted)	Deductible, then 30%	Deductible, then 20%	\$50 Copay
Chiropractic	\$10 Copay (up to 30 visits per year)	\$10 Copay (up to 30 visits per year)	\$5 Copay (up to 20 visits per year)
Acupuncture	Not Covered	Not Covered	Not Covered
Prescription Drug – Retail	(30-day supply)	(30-day supply)	(100-day supply except for Specialty, 30-day supply)
Generic	\$10 Copay	\$10 Copay	\$10 Copay
Brand Preferred	\$30 Copay	\$30 Copay	\$20 Copay
Most Specialty	\$35 Copay	\$30 Copay	\$20 Copay
Prescription Drug - Mail Order	(up to 100-day supply)	(up to 100-day supply)	(up to 100-day supply)
Generic	\$20 Copay	\$20 Copay	\$10 Copay
Brand Preferred	\$60 Copay	\$60 Copay	\$20 Copay
Most Specialty	N/A	20% coinsurance (not to exceed \$150) for up to a 30-day supply	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 Plans

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	Covered at 100%	Covered at 100%	Covered at 100%
Primary Care Physician / Specialist	\$40 Copay	\$30 Copay	\$30 Copay
Diagnostic Lab / X-Ray	No Charge	No Charge	No Charge
Urgent Care	\$40 Copay	\$30 Copay	\$30 Copay
Hospital Visits			
Inpatient Care	Deductible, then 30%	Deductible, then 10%	\$750 Per Admission
Outpatient Surgery	Deductible, then 30%	Deductible, then 10%	No Charge
Emergency Room (copay waived if admitted)	\$250 Copay	\$150 Copay	\$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 Brand	\$30 Copay	\$30 Copay	\$25 Copay
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 Brand	\$60 Copay	\$60 Copay	\$50 Copay
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.uhc2026/cvcl>

Choosing a network physician just got simpler

FINDING A DOCTOR, SPECIALIST OR FACILITY COULDN'T BE EASIER. JUST FOLLOW THE STEPS BELOW.

1. GO TO MYUHC.COM®

- Select **Find a Provider**
- Select **Medical Directory**
- Select **Employer and Individual Plans**

2. SELECT YOUR PLAN TYPE

UnitedHealthcare SignatureValue®

- Select SignatureValue Plans
- Select the state in which you live
- Select **SignatureValue Alliance HMO** for your network
- Enter your ZIP code or city and state

3. SEARCH BY PEOPLE OR PLACE

To search by people:

Select Primary Care, Specialty Care or Medical Groups

- For **Primary Care**: Select a type of Primary Provider (Family Doctor, Generalist, Internist, etc.)
- For **Specialty Care**: Select a type of **Specialist** (Acupuncturist, Allergist/Immunologist, etc.)
- For **Medical Groups**: Select your **Medical Group Name**

To search by place:

Select Hospitals or Specialty Centers

- For **Hospitals**: Select the Location
- For **Specialty Centers**: Select a type of Specialty Center (Birth Centers, Blood Banks, Community Clinics, etc.)

LEARN MORE

Scan this code with your phone to search our SignatureValue HMO providers.



Note:

- Members will need to select a primary care physician (PCP) at the time of enrollment. If you do not select a PCP during enrollment, a PCP in your geographic area who is accepting new patients will be assigned.
- Once a PCP has been selected, click on the Locations tab.

United Healthcare

SIGNATUREVALUE HMO

FIND CARE

SAVED

CHANGE PLAN >

Doctor Smith, MD

Internal Medicine

★★★★★ (3)

InNetwork

Save

OVERVIEW LOCATIONS PATIENT REVIEWS

5 Locations

ADJUST RADIUS

Within 1 Mile

Provider Location (1 of 5)

1234 Main Street
City, State 12345

0.6 Miles Away | Get Directions

(555) 555-5555 Phone

711 TTY

Accessibility VIEW ALL (8)

Exam Table and Scale >

Interior Building >

Signs >

Languages Spoken

Medical Staff
English

Office Staff
English

Affiliated Medical Groups

Medical Group A
ID: 00123456789 Copy

Medical Group B
ID: 0012345678 Copy

Medical Group C
ID: 001234567 Copy

Under the **Locations** tab, you will find the

Provider ID number. Please indicate the primary care physician's name and 10-digit ID number on your enrollment form.

United Healthcare

SIGNATUREVALUE HMO

FIND CARE

SAVED

CHANGE PLAN >

Doctor Smith, MD

Internal Medicine

★★★★★ (3)

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OVERVIEW LOCATIONS PATIENT REVIEWS

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English

Office Staff
English

Affiliated Medical Groups

Medical Group A
ID: 00123456789 Copy

Medical Group B
ID: 0012345678 Copy

Medical Group C
ID: 001234567 Copy

Important: Some PCPs may have more than one ID number based on their medical group, location or hospital affiliation. Please be sure you select the ID number that aligns with the medical group, location and hospital of your choice.

UnitedHealthcare	UHC PPO HSA	
	In-Network	Out-of-Network
Deductible* Individual / Family	\$3,500 / \$7,000	\$4,000 / \$8,000
Calendar Year Out-of-Pocket Maximum** Individual / Family	\$3,500 / \$7,000	\$7,000 / \$14,000
Lifetime Maximum Individual / Family	Unlimited	Unlimited
Office Visits		
Preventative Care	Covered at 100%	Not Covered Deductible, then 30%
Primary Care Physician / Specialist	Deductible, then 0%	Deductible, then 30%
Diagnostic Lab / X-Ray	Deductible, then 0%	Deductible, then 30%
Urgent Care	Deductible, then 0%	
Hospital Visits		
Inpatient Care	Deductible, then 0%	Deductible, then 30%
Outpatient Surgery	Deductible, then 0%	Deductible, then 30%
Emergency Room (copay waived if admitted)	Deductible, then 0%	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	Deductible, then \$10 Copay	Deductible, then \$10 Copay
Brand Preferred	Deductible, then \$30 Copay	Deductible, then \$30 Copay
Brand Non-preferred	Deductible, then \$50 Copay	Deductible, then \$50 Copay
Prescription Drug - Mail Order (up to 90-day supply)		
Generic	Deductible, then \$20 Copay	Not Covered
Brand Preferred	Deductible, then \$60 Copay	
Brand Non-preferred	Deductible, then \$100 Copay	

*All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount. You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

**All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

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.uhc2026/cvcl>

Telehealth

VIRTUAL VISIT WITH UNITEDHEALTHCARE

AMWELL, DOCTOR ON DEMAND, TELADOC

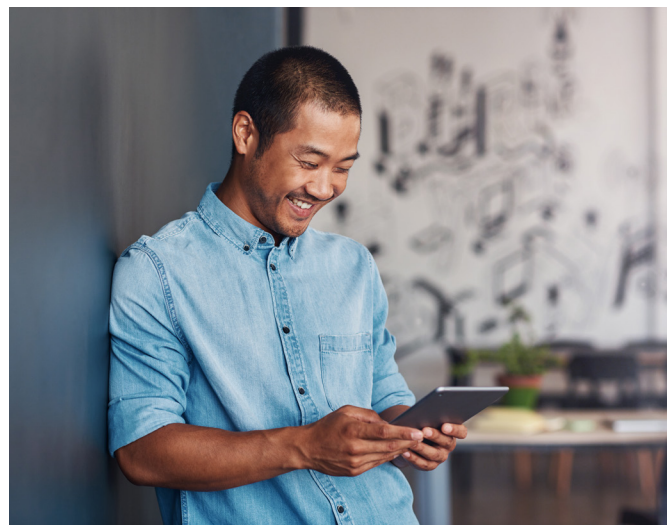
See a doctor whenever, wherever. Get 24/7 access to care from anywhere in the US with Virtual Visits. A Virtual Visit lets you see a doctor from your mobile device or computer without an appointment. Choose from an Amwell, Doctor On Demand, or Teladoc network provider and pay \$50 or less for the visit. 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 uhc2026/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.

**Contribute up to \$4,500 Single,
or \$9,000 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 2027 are \$4,500 for Single and \$8,900 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.

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

Administered by Delta Dental

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%.

Delta Dental	Low Plan		High Plan		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%
Prosthodontics (e.g., dentures and bridges)	50%	50%	50%	50%	50%	50%
Implants	N/A	N/A	N/A	N/A	60%	60%
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% \$5,000 lifetime maximum paid by Delta (Adult and dependent children)	

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

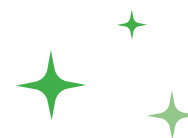


DENTAL INDEMNITY PLAN

Good dental care is essential to maintaining your overall health. The Indemnity Dental Plan, administered by Personify Health, offers a flexible option for your dental care needs. This plan allows you to visit any dentist of your choice without the restrictions of a network, giving you the freedom to select the provider that works best for you and your family.

The Indemnity Plan reimburses services based on Usual, Customary, and Reasonable (UCR) charges, ensuring fair coverage for the care you receive. UCR charges represent the standard fees that dentists in a specific geographic area typically charge for similar services. This means you'll be reimbursed up to the UCR amount for covered services, regardless of the dentist you choose. Unlike network-based plans, there are no in-network or out-of-network distinctions, so you'll receive the same level of reimbursement regardless of the dentist you choose. This plan is a great option for those who prefer flexibility and value the ability to see any dental provider.

Dental – Administered by Personify Health	Dental Indemnity Plan
	When visiting any Licensed Dentist You Pay:
Calendar Year Deductible Individual / Family	None
Calendar-Year Benefit Maximum (per person, per calendar year)	\$2,500
Diagnostic / Preventive Services (e.g., x-rays, cleanings, exams)	0% (Applies to Calendar Year Max)
Basic Services (e.g., fillings and sealants)	0%
Major Services (e.g. crowns, inlays, onlays & cast restorations)	10%
Prosthodontics (e.g., dentures and bridges)	50%
Implants	Not Covered
Occlusal Guards	50% to \$500 Lifetime Maximum
Orthodontia Services	Adult and Dependent Children : 0% \$2,000 Lifetime Maximum



Extra care for women for new life and midlife

Next Stage™ Women's Health

The Next Stage™ Women's Health program offers enhanced dental benefits and curated partner products and services to support women's overall well-being during pregnancy and menopause.

These pivotal life stages bring unique health challenges, including significant hormonal changes that impact oral health. Changes for pregnant women may include bleeding gums, gingivitis and oral growths ("pregnancy tumors"), while menopausal women may experience dry mouth, gum recession and tooth decay.

What you get with Next Stage™ Women's Health

When you opt in to the Next Stage™ Women's Health program, the following teeth and gum cleaning procedures are covered at 100% each group plan year.¹ These benefits are effective 24 hours after opting in to the program.²

Codes	Procedure	Next Stage™ Women's Health benefits
D0120	Oral exams	2 additional per year for up to 4 exams
D1110	Teeth cleaning (prophylaxis)	Any combination of up to 4 per year ³
D4910	Periodontal maintenance procedure	
D4346	Scaling in presence of moderate to severe gingival inflammation	
D0270, D0272, D0273, D0274, D0277	Additional X-rays (bitewings) ⁴	1 additional set per year
D1206, D1208	Topical application of fluoride – for adults	2 per year regardless of age



deltadentalins.com/members/womenshealth

Curated partner products and services

Delta Dental has also partnered with other companies to offer discounted women's health products and services to complement your benefits.

Midi Health

Meet with a clinician trained specifically in menopause and other aspects of female midlife health. Midi is a virtual clinic that provides specialty care for women in perimenopause and menopause.

Visit joinmidi.com/deltadental to get started.

Embr Labs

Embr Labs offers Embr Wave, the first wearable temperature device that intelligently delivers cooling sensations for immediate relief during hot flashes and night sweats.

Get yours at embrlabs.com/deltadental.



For more information and to enroll, visit deltadentalins.com/members/womenshealth.



¹ Next Stage™ Women's Health benefits are subject to any applicable maximums and deductibles under the terms and conditions outlined in your Evidence of Coverage. Please review your plan booklet for specific details about your coverage.

² This program is only for employer-sponsored group PPO plans. Your employer must have opted in to the program for you to be eligible. To join, you must have a qualifying health condition.

³ Please consult with your dentist about the exact procedure combinations required for your treatment.

⁴ Please consult with your dentist about the exact type and number of X-rays required.

Delta Dental PPO is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA - Delta Dental of California; PA, MD - Delta Dental of Pennsylvania; NY - Delta Dental of New York, Inc.; DE - Delta Dental of Delaware, Inc.; WV - Delta Dental of West Virginia, Inc. In TX, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

Vision Insurance

Administered by VSP

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize anetwork 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.

VSP	Low Plan		High Plan		Premium Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Examination	\$25 Copay	Reimbursement: Up to \$45	\$15 Copay	Reimbursement: Up to \$45	\$5 Copay	Reimbursement: Up to \$45
Frequency of Service						
Exam	Every 12 months		Every 12 months		Every 12 months	
Lenses	Every 24 months		Every 12 months		Every 12 months	
Frames	Every 24 months		Every 24 months		Every 12 months	
Elective Contact Lenses	Every 24 months		Every 12 months		Every 12 months	
Lenses		<u>Reimbursement:</u>		<u>Reimbursement:</u>		<u>Reimbursement:</u>
Single	Covered in Full	Up to \$45	Covered in Full	Up to \$45	Covered in Full	Up to \$45
Bifocal	Covered in Full	Up to \$65	Covered in Full	Up to \$65	Covered in Full	Up to \$65
Trifocal	Covered in Full	Up to \$85	Covered in Full	Up to \$85	Covered in Full	Up to \$85
Frames	<u>Allowance:</u> Up to \$160*	<u>Reimbursement:</u> Up to \$47	<u>Allowance:</u> Up to \$180*	<u>Reimbursement:</u> Up to \$47	<u>Allowance:</u> Up to \$210*	<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 \$160	<u>Reimbursement:</u> Up to \$105	Up to \$60 Copay for contact lens exam (fitting/evaluation) <u>Allowance:</u> Up to \$180	<u>Reimbursement:</u> Up to \$105	Up to \$60 Copay for contact lens exam (fitting/evaluation) <u>Allowance:</u> Up to \$210	<u>Reimbursement:</u> Up to \$105
LightCare	\$160 allowance for non-prescription sunglasses or non-prescription blue light filtering glasses instead of prescription glasses or contacts		\$180 allowance for non-prescription sunglasses or non-prescription blue light filtering glasses instead of prescription glasses or contacts		\$210 allowance for non-prescription sunglasses or non-prescription blue light filtering glasses instead of prescription glasses or contacts	

*Includes Costco, Walmart and Sam's Club.



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**.



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**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 Heatshield 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



Glossary of Medical 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.

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.

Legal Notices

Notice of Creditable Coverage

IMPORTANT NOTICE FROM SANTA CLARA COUNTY SCHOOLS' INSURANCE GROUP 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 Santa Clara County Schools' Insurance Group 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. Santa Clara County Schools' Insurance Group has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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 Santa Clara County Schools' Insurance Group 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 Santa Clara County Schools' Insurance Group medical plan, 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 Santa Clara County Schools' Insurance Group and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Santa Clara County Schools' Insurance Group 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 (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 or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 01, 2027
Name of Entity/Sender: Santa Clara County Schools' Insurance Group
Contact: Christina Brendle
61732 North First St., Ste. 100
Address: San Jose, California 95112
United States

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 **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 **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, 2026. Contact your state for more information on eligibility.

ALABAMA – Medicaid

<http://myalhipp.com>
855.692.5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
<http://myakhipp.com/> | 866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

<http://myarhipp.com>
855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
<http://dhcs.ca.gov/hipp>
916.445.8322 | Fax: 916.440.5676 | Email: hipp@dhcs.ca.gov

COLORADO – Medicaid and CHIP

Health First Colorado (Colorado's Medicaid Program)
<https://www.healthfirstcolorado.com>
Member Contact Center: 800.221.3943 | State Relay 711
Child Health Plan Plus (CHP+)
<https://hcpf.colorado.gov/child-health-plan-plus>
Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI)
<https://www.mycohibi.com/>
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid

www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html
877.357.3268

GEORGIA – Medicaid

GA HIPP: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
678.564.1162, Press 1
GA CHIPRA: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
678.564.1162, Press 2

ILLINOIS – Medicaid

Illinois Medicaid Premium Assistance Information
Medicaid application: <https://abe.illinois.gov>
HIPP Hotline Number: 217.524.8268 | HIPP Email: hfs.boc.hipp@illinois.gov

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
<https://www.in.gov/medicaid/> | 800.457.4584
Family and Social Services Administration
<http://www.in.gov/fssa/dfr/> | 800.403.0864

IOWA – Medicaid and CHIP (Hawki)

Medicaid: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid>
800.338.8366
Hawki: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki>
800.257.8563
HIPP: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp>
888.346.9562

KANSAS – Medicaid

<https://www.kancare.ks.gov/>
800.792.4884 | HIPP Phone: 800.967.4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
855.459.6328 | KIHIPPPROGRAM@ky.gov
KCHIP: <https://kynect.ky.gov> | 877.524.4718
Medicaid: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Medicaid: www.ldh.la.gov/healthy-louisiana
 Customer Service Line: 888.342.6207
 Medicaid Email: healthy@la.gov
 Louisiana Health Insurance Premium Program (LaHIPP):
<https://www.ldh.la.gov/lahipp>
 LaHIPP Phone: 877.697.6703 | LaHIPP Email: La.HIPP@la.gov
 LaHIPP Fax: 888.716.9787
 LaHIPP Mailing Address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid

Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US
 800.442.6003 | TTY: Maine relay 711
 Private Health Insurance Premium:
<https://www.maine.gov/dhhs/ofi/applications-forms>
 800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

<https://www.mass.gov/masshealth/pa>
 800.862.4840 | TTY: 711 | Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

<https://mn.gov/dhs/health-care-coverage/>
 800.657.3672

MISSOURI – Medicaid

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
 573.751.2005

MONTANA – Medicaid

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
 800.694.3084 | Email: HSHSHIPProgram@mt.gov

NEBRASKA – Medicaid

<http://www.ACCESSNebraska.ne.gov>
 Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid

<http://dhcfp.nv.gov>
 800.992.0900

NEW HAMPSHIRE – Medicaid

<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid>
 800.356.1561
 CHIP: <http://www.njfamilycare.org/index.html>
 800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392

NEW YORK – Medicaid

https://www.health.ny.gov/health_care/medicaid/
 800.541.2831

NORTH CAROLINA – Medicaid

<https://medicaid.ncdhhs.gov/>
 919.855.4100

NORTH DAKOTA – Medicaid

<https://www.hhs.nd.gov/healthcare>
 844.854.4825

OKLAHOMA – Medicaid and CHIP

<http://www.insureoklahoma.org>
 888.365.3742

OREGON – Medicaid and CHIP

<http://healthcare.oregon.gov/Pages/index.aspx>
 800.699.9075

PENNSYLVANIA – Medicaid and CHIP

<https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>
 800.692.7462
 CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
 CHIP Phone: 800.986.KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

<http://www.eohhs.ri.gov>
 855.697.4347 or 401.462.0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

<http://www.scdhhs.gov>
 888.549.0820

SOUTH DAKOTA – Medicaid

<http://dss.sd.gov>
 888.828.0059

TEXAS – Medicaid

<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
 800.440.0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)
<https://medicaid.utah.gov/upp/> | Email: upp@utah.gov | 888.222.2542
 Adult Expansion: <https://medicaid.utah.gov/expansion/>
 Utah Medicaid Buyout Program: <https://medicaid.utah.gov/buyout-program/>
 CHIP: <https://chip.utah.gov/>

VERMONT – Medicaid

<https://dvha.vermont.gov/members/medicaid/hipp-program>
 800.250.8427

VIRGINIA – Medicaid and CHIP

<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 and Chip: 800.432.5924

WASHINGTON – Medicaid

<https://www.hca.wa.gov/>
 800.562.3022

WEST VIRGINIA – Medicaid and CHIP

<https://dhhr.wv.gov/bms/> or <http://mywvhipp.com/>
 Medicaid: 304.558.1700
 CHIP Toll-free: 855.MyWVHIP (855.699.8447)

WISCONSIN – Medicaid and CHIP

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
 800.362.3002

WYOMING – Medicaid

<https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 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 ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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.
- Prostheses; and
- 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 the plan. Therefore, the following deductibles and coinsurance apply:

- **Plan 1:** Kaiser Deductible HMO Low Plan (Individual: 30% coinsurance and \$3,000 deductible; Family: 30% coinsurance and \$6,000 deductible)
- **Plan 2:** Kaiser Deductible HMO Mid Plan (Individual: 20% coinsurance and \$1,000 deductible; Family: 20% coinsurance and \$2,000 deductible)
- **Plan 3:** Kaiser Traditional HMO High Plan (Individual: 0% coinsurance and \$0 deductible; Family: 0% coinsurance and \$0 deductible)
- **Plan 4:** UHC HMO Low Plan (Individual: 30% coinsurance and \$500 deductible; Family: 30% coinsurance and \$1,000 deductible)
- **Plan 5:** UHC HMO Mid Plan (Individual: 10% coinsurance and \$250 deductible; Family: 10% coinsurance and \$500 deductible)
- **Plan 6:** UHC HMO High Plan (Individual: 0% coinsurance and \$0 deductible; Family: 0% coinsurance and \$0 deductible)
- **Plan 7:** UHC PPO HSA (Individual: 0% coinsurance and \$3,400 deductible; Family: 0% coinsurance and \$6,800 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at your District's Human Resources Department

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 they were covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2024. 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.

HIPAA Special Enrollment Rights

SANTA CLARA COUNTY SCHOOLS' INSURANCE GROUP HEALTH PLAN NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

Our records show that you are eligible to participate in the Santa Clara County Schools' Insurance Group Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact District's Human Resources Department

IMPORTANT WARNING

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

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 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.

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.

COBRA General Notice

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS (FOR USE BY SINGLE-EMPLOYER GROUP HEALTH PLANS) **CONTINUATION COVERAGE RIGHTS UNDER COBRA**

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.

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 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 period¹ 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

Santa Clara County Schools' Insurance Group
District's Human Resources Department
1732 North First St., Ste. 100
San Jose, California 95112-2617 United States

¹<https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>

Notes

Notes



This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

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