Santa Clara County Office of Education

URGENT

MEDICAL PLAN INFORMATION

OPEN ENROLLMENT DEADLINE

AUGUST 19, 2016






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Santa Clara County Office of Education
Jon R. Gundry
County Superintendent of Schools

August 8, 2016

Dear Employee:

This booklet is designed to provide guidance should you decide to make changes to your health care benefits during the Santa Clara County Office of Education's 2016 Open Enrollment period (deadline: August 19). To help in this process, we have highlighted some plan changes:

- The Anthem PPO-Select Network plan is no longer available. In order to offer a similarly priced plan, we are adding a PPO-Full Network plan that has a $500/$1000 deductible.
- A buy-up option for the dental plan is now available. The cost of this option is $27.23/mo. Part-time employees would incur this additional cost on top of their normal monthly premium. This plan offers 100% coverage in and out of network as well as a $2000 orthodontic benefit. A two year commitment is required (see comparison on page 3).
- We are expanding our vision coverage; the frame allowance has been increased to $150 (from $110).

This booklet contains medical plan comparison tables that detail office visit fees, hospital co-payments, prescription coverage, deductibles and co-insurance. Also included are the new monthly rates for full time and part-time employees. Part-time employees will have additional payroll deductions, which may be prorated over a 10-month or 11-month period. The effective date for all changes is October 1, 2016, the beginning of the new plan year. Note that deductibles accumulate by calendar year, January through December. Please review these tables to help you make the best decision for you and your family.

The County Office will hold open enrollment meetings to help clarify health plan options (see table below). **The meetings will be held on a walk-in basis, no appointments are needed.** Representatives from SISC and the benefits staff will be available to answer questions.

The deadline to make any benefits changes is August 19, 2016. To make changes, submit your form today. The sooner you enroll, the sooner you will receive your new medical plan cards. **If you are not making any changes for this plan year, you will NOT need to submit any forms.** If you have any questions or concerns, please do not hesitate to contact your Employee Benefits Specialist.

Sincerely,

Candice Harris
Director-Human Resources

Date	Time	Location
August 11, 2016	12:30-4:00 p.m.	SCCOE-Saratoga room 1290 Ridder Park, San Jose
August 17, 2016	12:30-5:00 p.m.	SCCOE-Gilroy room 1290 Ridder Park, San Jose
August 18, 2016	12:30-5:00 p.m.	SCCOE-Saratoga room 1290 Ridder Park, San Jose

To-Do List

- ✓ Compare medical plan descriptions and determine cost.
- ✓ Select the best plan for you and your family based on your medical needs. Consider the following:
    - How many times did you and your family see the doctor last year?
    - How much did you spend on doctor visit co-pays, deductibles, and prescriptions?
    - How much did you pay in payroll deductions last year?
    - Estimate what services you may need this year.
- ✓ IF you are changing medical plans, adding or deleting dependents, complete an enrollment form. **If you have no changes, a form is not needed.**
- ✓ IF you have a dependent 19-25 years of age, he/she must be a full time student and have a student certification form submitted to be enrolled in dental, vision and the Employee Assistance Program.
- ✓ **Mail forms to SCCOE/Benefits MC 264, 1290 Ridder Park Drive, San Jose, CA 95131. You can also email or fax your documents to your Employee Benefits Specialist below by 5 p.m. August 19, 2016.**

Need Help?

Employee Benefits Specialists can answer questions about enrollment and eligibility.

Employee Benefits Specialist	Last name beginning	Phone number	Fax number	email
Tina Cordoba	A-G	(408) 453-6831	(408) 453-3660	tina_cordoba@sccoe.org
Loraine Hobgood	H-O	(408) 453-4355	(408) 453-3658	loraine_hobgood@sccoe.org
Patty Tijerina	P-Z	(408) 453-6681	(408) 453-3659	patty_tijerina@sccoe.org

Health Care Cost Containment Committee

Name	Representing	email
Philip Gordillo	Co-Chair	philip_gordillo@sccoe.org
Candice Harris	Co-Chair	candice_harris@sccoe.org
Karyn Kikuta	ACE/CTA	karyn_kikuta@sccoe.org
Lisa Vieler	ACE/CTA	livelier@aol.com
Riju Krishna	ACT/CTA	riju_Krishna@sccoe.org
Tara Guerrero	ACT/CTA	tara_guerrero@sccoe.org
Sandy Fakaosi	SEIU – Paraeducators	sandra_fakaosi@sccoe.org
Rochelle Velazquez	SEIU – OTBS	rochelle_velazquez@sccoe.org
Edwina Davies	Psychologists/Social Workers	edwina_davies@sccoe.org
Craig Blackburn	Leadership Team	craig_blackburn@sccoe.org
Barbara Coats	Risk Management - Resource	barbara_coats@sccoe.org

Dental Plan Comparison

Benefits	Delta Dental of California		Delta Dental Buy-Up Option	
	In-Network PPO	**Out-of-Network Premier**	**In-Network PPO**	**Out-of-Network Premier**
Calendar Year Maximum per enrollee	$2,000	$1,500	$2,500	$2,000
Calendar Year Deductible				
Individual	None	None	None	None
Diagnostic and Preventive				
Exams & Cleaning - three per year	100%	70-100%	100%	100%
X-rays	100%	70-100%	100%	100%
Basic Services				
Fillings, simple tooth extractions, sealants	70-100%	70-100%	100%	100%
Endodontics				
Covered Under Basic Services	70-100%	70-100%	100%	100%
Periodontics				
Covered Under Basic Services	70-100%	70-100%	100%	100%
Oral Surgery				
Covered Under Basic Services	70-100%	70-100%	100%	100%
Major Services				
Crowns, inlays, onlays and cast restorations	70-100%	70-100%	100%	100%
Prosthodontic Services				
Construction or repair	70%	70%	100%	100%
Orthodontic Benefits				
Adults and dependent children	50%	50%	50%	50%
Maximum	$1000 maximum life-time benefit per enrollee		$2000 maximum life-time benefit per enrollee	
Eligibility	Primary enrollee, spouse, domestic partner and eligible dependent children to age 19 or to age 25 if dependent is a full time student.		Primary enrollee, spouse, domestic partner and eligible dependent children to age 19 or to age 25 if dependent is a full time student.	

Medical Plan Cost

Kaiser HMO will cost **$19,308.00** per year.

Kaiser HMO	Total Monthly Premium	SCCOE Contribution	Your monthly payroll deduction (12 month)	Your monthly payroll deduction (11 month)	Your monthly payroll deduction (10 month)
Part-time (5.5 hrs/day)	$1,609.00	$1,006.74	$602.26	$657.01	$722.71
Full-time	$1,609.00	$1,071.00	$538.00	$586.91	$645.60

Kaiser Deductible DHMO will cost **$14,232.00** per year.

Kaiser DHMO	Total Monthly Premium	SCCOE Contribution	Your monthly payroll deduction (12 month)	Your monthly payroll deduction (11 month)	Your monthly payroll deduction (10 month)
Part-time (5.5 hrs/day)	$1,186.00	$1,006.74	$179.26	$195.56	$215.11
Full-time	$1,186.00	$1,071.00	$115.00	$125.45	$138.00

Kaiser High Deductible Health Plan (HDHP) with Health Savings Account (HSA) option will cost **$11,964.00** per year.

Kaiser HDHP	Total Monthly Premium	SCCOE Contribution	Your monthly payroll deduction (12 month)	Your monthly payroll deduction (11 month)	Your monthly payroll deduction (10 month)
Part-time (5.5 hrs/day)	$997.00	$937.18	$59.82	$65.26	$71.78
Full-time	$997.00	$997.00	$0	$0	$0

Anthem PPO (Full Network) will cost **$22,572.00** per year. To locate a doctor go to www.anthem.com/ca/SISC.

Anthem PPO (Full Network)	Total Monthly Premium	SCCOE Contribution	Your monthly payroll deduction (12 month)	Your monthly payroll deduction (11 month)	Your monthly payroll deduction (10 month)
Part-time (5.5 hrs/day)	$1,881.00	$1,006.74	$874.26	$953.74	$1,049.11
Full-time	$1,881.00	$1,071.00	$810.00	$883.64	$972.00

NEW PLAN FOR 2016/2017

Anthem PPO (Deductible Plan) will cost **$20,400.00** per year. To locate a doctor go to www.anthem.com/ca/SISC.

Anthem PPO (Deductible Plan)	Total Monthly Premium	SCCOE Contribution	Your monthly payroll deduction (12 month)	Your monthly payroll deduction (11 month)	Your monthly payroll deduction (10 month)
Part-time (5.5 hrs/day)	$1,700.00	$1,006.74	$693.26	$756.28	$831.91
Full-time	$1,700.00	$1,071.00	$629.00	$686.18	$754.80

Anthem PPO High Deductible Health Plan (HDHP) with Health Savings Account (HSA) option will cost **$13,212.00** per year.

Anthem PPO HDHP (Full Network)	Total Monthly Premium	SCCOE Contribution	Your monthly payroll deduction (12 month)	Your monthly payroll deduction (11 month)	Your monthly payroll deduction (10 month)
Part-time (5.5 hrs/day)	$1,101.00	$1,006.74	$94.26	$102.83	$113.11
Full-time	$1,101.00	$1,071.00	$30.00	$32.73	$36.00

Delta Dental of California will cost **$1,641.00** per year.

Delta Dental	Total Monthly Premium	SCCOE Contribution	Your monthly payroll deduction (12 month)	Your monthly payroll deduction (11 month)	Your monthly payroll deduction (10 month)
Part-time (5.5 hrs/day)	$136.75	$128.55	$8.21	$8.95	$9.85
Full-time	$136.75	$136.75	$0	$0	$0

Buy-Up Option for Delta Dental of California will cost **$1,965.00** per year.

Delta Dental	Total Monthly Premium	SCCOE Contribution	Your monthly payroll deduction (12 month)	Your monthly payroll deduction (11 month)	Your monthly payroll deduction (10 month)
Part-time (5.5 hrs/day)	$163.98	$128.55	$35.44	$38.66	$42.53
Full-time	$163.98	$136.75	$27.23	$29.71	$32.68

Medical Eye Services (MES) will cost **$155.64** per year.

MES Vision	Total Monthly Premium	SCCOE Contribution	Your monthly payroll deduction (12 month)	Your monthly payroll deduction (11 month)	Your monthly payroll deduction (10 month)
Part-time (5.5 hrs/day)	$12.97	$12.19	$0.78	$0.85	$0.93
Full-time	$12.97	$12.97	$0	$0	$0

SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

Santa Clara County Office of Education
SISC Anthem Blue Cross PPO and Kaiser Plans - A Brief Comparison
Effective October 1, 2016

SISC Plan Name	Anthem PPO - Full Network	Anthem PPO Deductible Plan - Full Network	Anthem HDHP - HSA
Provider Network(s): **Hospital & Professional**	**Available in Full Prudent Buyer Network**	**Available in Full Prudent Buyer Network**	**Available in Full Prudent Buyer Network**
Calendar Year Deductible(s) *The deductible is the amount member pays before the Plan starts to pay at benefit level.*	**No deductible**	**$500** per individual up to **$1,000** per family	**$3,000** per individual up to **$5,200** per family
Calendar Year Out of Pocket Maximum	**$1,000** per individual up to **$3,000** per family	**$1,000** per individual up to **$3,000** per family	**$5,000** per individual up to **$10,000** per family
Co-insurance is the member's responsibility to pay when the Plan is paying less than 100% (ie. Plan pays 80%, member pays 20%)	The Annual Out of Pocket Maximum includes the member's co-pays on Medical only.	The Annual Out of Pocket Maximum includes the member's co-pays on Medical only.	This plan's Annual Out of Pocket Maximum includes the member's deductible, 10% coinsurance and co-pays for medical and Rx.
Services	**Participating In-network Providers**	**Participating In-network Providers**	**Participating In-network Providers**
Office Visits **(co-pays will apply to Out-of-Pocket maximum)**	$20 co-pay	$30 co-pay	10% after deductible
Routine Preventative Care for Adults and Children all ages + Adult Routine Cancer Screenings (industry standard)	No co-pay	No co-pay	Deductible Waived, 100%
Outpatient Laboratory and X-Ray	No co-pay	No co-pay (after deductible)	10% after deductible
Inpatient Hospital & Ambulatory Surgery Ctr Room, Board & Support Services (prior authorization required)	No co-pay	No co-pay (after deductible)	10% after deductible
Emergency Room/Accident Care	$100 co-pay, waived if admitted	$100 co-pay (after deductible)	$100 co-pay, waived if admitted
Facility & Professional Expenses: *medical emergencies as defined by the Plan	No co-pay	No co-pay (after deductible)	10% after deductible
Professional Charges - Physical Medicine (OT, PT, Chiro), DME (rental or purchase), Ambulance (air or ground), Home Health Care and Home Infusion (some limits may apply)	No co-pay, Some limits apply	No co-pay (after deductible), Some limits apply	10% after deductible
Acupuncture (12 visits per year)	No co-pay up to 12 visits	No co-pay (after deductible), up to 12 visits	10% after deductible
Psychiatric & Substance Abuse			
Inpatient	No co-pay	No co-pay (after deductible)	10% after deductible
Outpatient	$20 co-pay	$30 co-pay	10% after deductible

Outpatient Prescription Drugs	SISC Rx Plan 5-20		SISC Rx Plan 7-25		Anthem Rx Plan (Express Scripts)	
	Retail 30-day supply	**Costco Retail or Mail** 90-day supply	**Retail** 30-day supply	**Mail** 90-day supply	**Retail** 30-day supply	**Mail** 90-day supply
Most Generic Drugs	$5	$0	$7	$0	$9	$18
Single Source Brand Name Drugs	$20	$50	$25	$60	$35	$90
Multi Source Brand Name Drugs	$5 + brand/generic cost difference	$15 + brand/generic cost difference	$25	$60	$35	$90
Brand Only - Calendar Year Deductible	Not applicable		Not applicable		**Subject to medical deductible. Co-pays only apply after the medical deductible has been met.**	
Out of Pocket (OOP) Maximum for outpatient prescription drugs	$1,500 individual/ $2,500 family		$1,500 individual/ $2,500 family		Included in Medical OOP Maximum	

Note: This is a brief benefit summary that reflects in-network benefits from a participating or contracted provider. For additional details, limitations, exclusions and out-of-network coverage, please refer to the Summary of Benefits or Coverage Booklet. For Anthem, Out-of-network benefits are paid at non-participating fee (a much lower payment) and subject to additional limits.

SISC III
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Santa Clara County Office of Education
SISC Anthem Blue Cross PPO and Kaiser Plans - A Brief Comparison
Effective October 1, 2016

SISC Plan Name	Kaiser HMO	Kaiser Deductible Plan - DHMO	Kaiser High Deductible Plan - HDHP
Provider Network(s): **Hospital & Professional**	**Kaiser**	**Kaiser**	**Kaiser**
Calendar Year Deductible(s) *The deductible is the amount member pays before the Plan starts to pay at benefit level.*	**No deductible**	**$1,000** per individual up to **$2,000** per family	**$1,500** per individual up to **$3,000** per family
Calendar Year Out of Pocket Maximum	**$1,500** per individual up to **$3,000** per family	**$3,000** per individual up to **$6,000** per family	**$3,000** per individual up to **$6,000** per family
Co-insurance is the member's responsibility to pay when the Plan is paying less than 100% (ie. Plan pays 80%, member pays 20%)	The Annual Out of Pocket Maximum includes co-pays for medical and Rx	The Annual Out of Pocket Maximum includes the member's deductible and co-pays for medical and Rx	The Annual Out of Pocket Maximum includes the member's deductible and co-pays medical and Rx
Services	**Participating In-network Providers**	**Participating In-network Providers**	**Participating In-network Providers**
Office Visits **(co-pays will apply to Out-of-Pocket maximum)**	$30 co-pay	Deductible Waived, $20 co-pay	10% after deductible
Routine Preventative Care for Adults and Children all ages + Adult Routine Cancer Screenings (industry standard)	No co-pay	Deductible Waived, 100%	Deductible Waived, 100%
Outpatient Laboratory and X-Ray	No co-pay	Deductible Waived Complex imaging: $50; all other $10	10% after deductible
Inpatient Hospital & Ambulatory Surgery Ctr Room, Board & Support Services (prior authorization required)	No co-pay	20% after deductible	10% after deductible
Emergency Room/Accident Care Facility & Professional Expenses: *medical emergencies as defined by the Plan	$100 co-pay, waived if admitted No co-pay	20% after deductible	10% after deductible
Professional Charges - Physical Medicine (OT, PT, Chiro), DME (rental or purchase), Ambulance (air or ground), Home Health Care and Home Infusion (some limits may apply)	Most services no charge. Refer to Benefit Summary or EOC for details. Ambulance Services $50 per trip.	Some co-pays apply, some require 20%. Refer to Benefit Summary or EOC for details. Ambulance $150 per trip.	10% after deductible. Refer to Benefit Summary or EOC for details. Ambulance $150 per trip.
Acupuncture/Chiropractic	$10 co-pay (up to 30 visits combined)	$10 co-pay (up to 30 visits combined)	10% after deductible
Psychiatric & Substance Abuse			
Inpatient	No co-pay	20% after deductible	10% after deductible
Outpatient	$30 co-pay	Deductible Waived, $20 co-pay	10% after deductible

Outpatient Prescription Drugs	Kaiser Rx Plan 10-30		Kaiser Rx Plan 10-30		Kaiser Rx Plan (copays after deductible)	
	Kaiser Pharmacy 100-day supply	**Kaiser Pharmacy** 100-day supply	**Kaiser Pharmacy** **30**-day supply	**Kaiser Pharmacy** 100-day supply	**Kaiser Pharmacy** **30**-day supply	**Kaiser Pharmacy** 100-day supply
Most Generic Drugs	$10	$10	$10	$20	$10	$20
Single Source Brand Name Drugs	$30	$30	$30	$60	$30	$60
Multi Source Brand Name Drugs	$30	$30	$30	$60	$30	$60
Brand Only - Calendar Year Deductible	Not applicable		Not applicable		**Subject to medical deductible. Co-pays only apply after the medical deductible has been met.**	
Out of Pocket (OOP) Maximum for outpatient prescription drugs	Included in Medical OOP Maximum		Included in Medical OOP Maximum		Included in Medical OOP Maximum	

ANTHEM – INSTRUCTIONS FOR COMPLETING THE SISC III ENROLLMENT FORM

1. Designate your plan selection at the top of the form: “HSA”, “PPO” or “PPO-DED”.
2. Complete your personal information in Section II of the form ensuring that each field is complete. There are three boxes in this section that are not required: “IPA”, “PCP”, and “Current Provider”. All other fields must be complete.
3. Complete personal information for covered dependents into Section III of the form. There are three boxes in this section that are not required: “IPA”, “PCP”, and “Current Provider”. All other fields must be complete.
4. Sign and date your completed form.
5. If you are enrolling dependents that are not currently covered, you must submit supporting documentation with your enrollment form.
    a. Spouse: Marriage certificate and front page of most recent income tax return with income data blackened out.
    b. Domestic partner: State issued certificate of registered domestic partnership
    c. Child up to age 26: Birth certificate
    d. Guardianship up to age 18: Court paperwork establishing guardianship
    e. Adoption: Adoption paperwork
    f. Disabled dependent over age 26: proof of 6 months of prior creditable coverage, completed Anthem certification form, front page of most recent tax return showing the child listed as a dependent, birth certificate.
6. Submit the completed paperwork no later than August 19, 2016.

☐HSA ☐PPO ☐PPO-DED

SISC III ENROLLMENT FORM – (~~DO NOT~~ use for Kaiser members, use Kaiser Permanente enrollment form for Kaiser members)

(Type or print clearly in black ink)

SECTION I: SELECTED COVERAGE – REQUIRED (DISTRICT USE ONLY)

ENROLLMENT REASON: ☐ NEW HIRE ☐OPEN ENROLLMENT ☐ EMPLOYEE STATUS CHANGE ☐ LOSS OF COVERAGE ☐COBRA

QUALIFYING DATE: ____________ EFFECTIVE DATE: ____________ HIRE DATE: _______________ DISTRICT APPROVED INITIALS: ___________

DISTRICT NAME (DO NOT ABBREVIATE)	EMPLOYEE GROUP (BARGANING UNIT)	HOURS WORKED PER WEEK	☐75% OPTION - PROVIDE SPOUSE SOCIAL SECURITY NO.
Santa Clara County Office of Education	☐Certificated ☐Classified ☐Management	n/a	n/a

MEDICAL GROUP NO.	DELTA DENTAL GROUP NO.	VISION GROUP NO.	LIFE GROUP NO.
	n/a	n/a	n/a

SECTION II: EMPLOYEE / APPLICANT INFORMATION - REQUIRED

MEDICAL

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	DATE OF BIRTH	☐ MALE ☐ FEMALE
				/ /	

STREET ADDRESS	CITY	STATE	ZIP

TELEPHONE NO.	E-MAIL ADDRESS	IPA (HMO ONLY–REQUIRED)	PCP (HMO ONLY–REQUIRED)	CURRENT PROVIDER?
( )				☐ YES ☐ NO

MEDICARE COVERAGE If you are retired and entitled to Medicare and not enrolled, you may be subject to a premium surcharge.

Are you retired? ☐ YES ☐ NO

If yes, do you have Medicare? ☐ YES ☐ NO

(Copy of Medicare card required)

Do any of your dependents have Medicare? ☐ YES ☐ NO

(Copy of Medicare card required)

SECTION III: DEPENDENT INFORMATION Proof of eligibility required (i.e. birth/marriage/domestic partner certificate)

MEDICAL

☐Spouse ☐Domestic Partner Gender ☐M ☐F	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN?	ENROLLED IN OTHER HEALTH PLAN?	DATE OF BIRTH	TOTALLY DISABLED?	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER?
☐ YES ☐ NO	☐ YES ☐ NO	/ /	☐ YES ☐ NO			☐ YES ☐ NO

MEDICAL

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN?	ENROLLED IN OTHER HEALTH PLAN?	DATE OF BIRTH	TOTALLY DISABLED?	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER?
☐ YES ☐ NO	☐ YES ☐ NO	/ /	☐ YES ☐ NO			☐ YES ☐ NO

MEDICAL

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN?	ENROLLED IN OTHER HEALTH PLAN?	DATE OF BIRTH	TOTALLY DISABLED?	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER?
☐ YES ☐ NO	☐ YES ☐ NO	/ /	☐ YES ☐ NO			☐ YES ☐ NO

MEDICAL

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN?	ENROLLED IN OTHER HEALTH PLAN?	DATE OF BIRTH	TOTALLY DISABLED?	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER?
☐ YES ☐ NO	☐ YES ☐ NO	/ /	☐ YES ☐ NO			☐ YES ☐ NO

- I understand it is my responsibility to notify my district once a dependent is no longer eligible due to divorce or over age children. If I fail to report loss of eligibility I may be financially liable to SISC if claims were paid on behalf of non-eligible individuals.
- **DEDUCTION AUTHORIZATION:** If applicable, I authorize my school district to deduct from my wages the required contribution.
- **NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- **HIV Testing Prohibited:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
- **EFFECTIVE DATE:** The effective date of coverage is subject to SISC III approval.
- Any complaints regarding the exemption due to the Knox-Keene Health Care Service Plan Act of 1975 may be directed to the Department of Managed Health Care of the State of California.

SECTION IV: SIGNATURE OF UNDERSTANDING – APPLICANT MUST SIGN

I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements.

ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. SISC III AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

____

Applicant Signature Required Date

KAISER – INSTRUCTIONS FOR COMPLETING THE KAISER ENROLLMENT FORM

1. In section A, select the Kaiser plan you are enrolling in.
2. Complete your personal information in section B ensuring that every field is complete (MRNs are not necessary).
3. Complete personal information for any dependents enrolling on the plan into section C of the form (MRNs not necessary).
4. Sign and date your completed form.
5. If you are enrolling new dependents that are not currently covered, you must submit supporting documentation with your enrollment form.
    a. Spouse: Marriage certificate and front page of most recent income tax return with income data blackened out.
    b. Domestic partner: State issued certificate of registered domestic partnership
    c. Child up to age 26: Birth certificate
    d. Guardianship up to age 18: Court paperwork establishing guardianship
    e. Adoption: Adoption paperwork
    f. Disabled dependent over age 26: Most recent Kaiser certification, front page of most recent tax return showing the child listed as a dependent, birth certificate
6. Submit your completed paperwork no later than August 19, 2016

California Region Kaiser Permanente Group Enrollment/Change Form

Please print or type in black ink only. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER:		
District Name: SANTA CLARA COUNTY OFFICE OF EDUCATION		Hire Date (mm/dd/yyyy)
Medical Group Number:	Enrollment Unit:	Effective Enrollment/ Change Date (mm/dd/yyyy)

Complete this section **ONLY** if dental, vision and/or life insurance is offered through SISC:

Delta Dental Group#: N/A Vision Group#: N/A SISC Life Ins Group#: Employee Only N/A

75% premium option list spouse SS#_____

A. ENROLLMENT/CHANGE REASON: (see Change Table for assistance) New group: Yes ☐ ☐ No

☐ New Hire (complete sections A, B, C, D) ☐ Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) ☐ HMO Plan ☐ Deductible Plan ☐ High Deductible Plan

☐ Loss of Other Coverage (complete sections A, B, C, D) ☐ Other (please specify) _____

☐ Name Change (complete sections A, B, C, D) From: _____ To: _____

Event Date (mm/dd/yyyy) _____

B. EMPLOYEE: Have you ever been a Kaiser Permanente member? ☐ Yes ☐ No

Medical Record No. (if known)	Social Security No.	Gender M ☐ F ☐
Name (Last, First, MI)	Birth Date (mm/dd/yyyy)	
Home Address	City State ZIP	
Work Phone	Home Phone Email	
Ethnicity	Preferred Language	

C. FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)

☐ Add ☐ Delete ☐ Spouse ☐ Domestic partner Spouse/domestic partner name: Gender Male: ☐ Female: ☐	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Delete ☐ Son ☐ Daughter Dependent name:	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Delete ☐ Son ☐ Daughter Dependent name:	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Delete ☐ Son ☐ Daughter Dependent name:	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

Do any of dependents above live at another address? ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

D. Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of* Coverage.

Signature required for all Kaiser Permanente Plans **Date**
(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

**Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

KAISERPERMANENTE

Santa Clara County Office of Education

☐ **Change**
☐ **New Hire**
☐ **Open Enrollment**

DENTAL/VISION PLAN ENROLLMENT FORM

Effective Date: _____ **Qualifying Event Date:** _____

I. EMPLOYEE INFORMATION **Qualifying Event** _____

DATE OF HIRE	DATE ELIGIBLE	DATE OF BIRTH	SOC. SEC. NO.	
LAST NAME	FIRST	MI		HOME PHONE (Including area code)
STREET ADDRESS	CITY	STATE	ZIP	SEX (check) M ☐ / F ☐
Marital Status:	☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐Divorced ☐ Domestic Partner		DATE OF UNION	CHILDREN ☐ Yes ☐ No

II. COVERAGE ELECTION (Complete dependent information section if coverage elected for spouse, children and/or domestic partner)

Dental Election – Delta Dental
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

Dental Buy-Up Option – Delta Dental (*Enrollment Requires Two Year Commitment and Additional Monthly Premium)*
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

Vision Election – Medical Eye Services
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

COVERED DEPENDENT INFORMATION –Dental, Vision ☐ Add ☐ Delete

NAME	SOCIAL SECURITY NUMBER	SEX M/F	DATE OF BIRTH	Over age 18 FULL TIME STUDENT
SPOUSE / DOMESTIC PARTNER				☐ **Y** ☐ **N**
DEPENDENT				☐ **Y** ☐ **N**
DEPENDENT				☐ **Y** ☐ **N**
DEPENDENT				☐ **Y** ☐ **N**
DEPENDENT				☐ **Y** ☐ **N**
DEPENDENT				☐ **Y** ☐ **N**

III. PRE-TAX PREMIUM DEDUCTIONS- Section 125 Premium Only Plan

You must make an active election for each calendar year. If you enrolled in one of these plans for the current calendar year, we will not automatically re-enroll you for the new calendar year. You must re-enroll each year.

☐ Please check this box if you ***do not*** want your premiums deducted on a pre-tax basis

IV. BENEFICIARY DESIGNATION

BENEFICIARY- LIFE INSURANCE- STANDARD INSURANCE CO. ($20,000 CL/CE or $50,000 Leadership Team)

Please complete an attached list if you want to name more persons than provided for on this form.

NAME OF BENEFICIARY (LAST, FIRST, MI)	SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE
ADDRESS OF BENEFICIARY (STREET/CITY/STATE/ZIP CODE)		% OF BENEFIT
NAME OF BENEFICIARY (LAST, FIRST, MI)	SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE
ADDRESS OF BENEFICIARY STREET/CITY/STATE/ZIP CODE		% OF BENEFIT
IF THE BENEFICIARY DIES BEFORE ME, I DESIGNATE AS CONTINGENT BENEFICIARY-NAME OF BENEFICIARY (LAST, FIRST, MI)	SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE
ADDRESS OF CONTINGENT BENEFICIARY (STREET/CITY/STATE/ZIP CODE)		% OF BENEFIT

EMPLOYEE SIGNATURE X _____ **DATE** _____

BENEFICIARY- BUSINESS TRAVEL ACCIDENT- MUTUAL OF OMAHA ($100,000 max)

☐ SAME AS ABOVE _____

POLICY NUMBER: T5MP-30040

Please complete an attached list if you want to name more persons than provided for on this form.

Beneficiary for Death Benefits – Right to Change Beneficiary is Reserved to the Insured. (If more than one beneficiary is named, the beneficiaries shall share equally unless otherwise stated below.)

NAME OF BENEFICIARY (LAST, FIRST, MI)	% OF BENEFIT	RELATIONSHIP TO EMPLOYEE

BENEFICIARY- PERSONAL ACCIDENT- CIGNA ($1000 basic coverage)

☐ SAME AS ABOVE _____

Please complete an attached list if you want to name more persons than provided for on this form.

NAME OF BENEFICIARY (LAST, FIRST, MI)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
ADDRESS OF BENEFICIARY (STREET/CITY/STATE/ZIP CODE)		% OF BENEFIT
IF THE BENEFICIARY DIES BEFORE ME, I DESIGNATE AS CONTINGENT BENEFICIARY-NAME OF BENEFICIARY (LAST, FIRST, MI)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
ADDRESS OF CONTINGENT BENEFICIARY (STREET/CITY/STATE/ZIP CODE)		% OF BENEFIT

V. WAIVER OF BENEFITS (FOR EMPLOYEE'S THAT WORK LESS THAN .9 FTE. Check all that apply)

I hereby certify that I have been given the opportunity to participate in benefits available to me through the Santa Clara County Office of Education Benefits plan. After careful consideration, **I have decided not to participate in the following insurance plans and coverage:**

☐ EMPLOYEE:	☐ Medical	☐ Dental	☐ Vision	☐ Life
☐ SPOUSE OR DOMESTIC PARTNER:	☐ Medical	☐ Dental	☐ Vision	
☐ DEPENDENT CHILDREN: (to age 19 or fulltime student to age 25)	☐ Medical	☐ Dental	☐ Vision	

REASON FOR DECLINING THIS COVERAGE *(Must be completed)*:

I have other medical insurance coverage ☐ Yes ☐ No

I understand I will not be able to enroll in these benefits again until:

_____ I contact an Employee Benefits Specialist and complete the required forms during the open enrollment period.

_____ I lose my other medical insurance coverage

_____ AUTOMATIC WAIVER FOR PART-TIME EMPLOYEES: YOU HAVE NOT COMPLETED THE NECESSARY FORMS FOR FRINGE BENEFIT ENROLLMENT WITHIN THE 30 DAY PERIOD FROM YOUR DATE OF HIRE AS SPECIFIED IN YOUR OFFER LETTER. YOU WILL HAVE THE OPPORTUNITY TO ENROLL AGAIN AS SPECIFIED ABOVE AND MAY HAVE TO PROVIDE SATISFACTORY MEDICAL EVIDENCE OF INSURABILITY TO BE COVERED AT A LATER DATE

If you work less than full-time and receive less than the amount that is contributed towards a full-time employee, you may decline coverage. If you are waiving coverage under *Santa Clara County Office of Education's Benefits* plan because you and your dependent(s) have coverage under another employer's benefit plan, please indicate that above. If you are waiving coverage for yourself and your dependent(s) because of other insurance coverage, you may in the future be able to enroll yourself and/or your dependent(s) in the *Santa Clara County Office of Education's Benefits* plan, provided that you request enrollment within 30 days after your other coverage ends, because of a family status change as listed below:

1. **Spouse's or domestic partner's termination of employment or change of employment status.**
2. **Termination of the other employer's benefit plan.**
3. **The other employer stops paying a required contribution for spouse's or domestic partner's coverage.**
4. **Death of, or divorce from, the person through which you were covered.**

WAIVER OF COVERAGE AGREEMENT:

By signing this form I have agreed to waive my employer-paid benefits. I understand that my election cannot be changed during the plan year. The only exception to this would be in the event I have a change in family status as defined under IRS regulations.

EMPLOYEE SIGNATURE X _____ **DATE** _____

VI. RELEASE

I hereby certify that I am an eligible employee/beneficiary as defined in the Summary Plan Document that the above information is complete and accurate, and all claims submitted will be for individuals who are eligible members of the health plan. I hereby authorize the Plan Sponsor to deduct, from my pay, my contributions to the cost of the benefits, which I indicated above and for which I am or may become eligible. The current benefits have been explained to me thoroughly. I understand that I am responsible for a greater portion of my health costs in excess of the amounts payable under the plan.

THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ, UNDERSTOOD, AND AGREE TO ALL SECTIONS AND THE TERMS OF THIS ENROLLMENT FORM.

EMPLOYEE SIGNATURE X _____ **(Required) DATE** _____

TO BE COMPLETED BY SANTA CLARA COUNTY OFFICE HUMAN RESOURCES ONLY			
Medical Insurance	Date Entered	Delta Dental	Date Entered
QCC Updates	Date Entered	Vision	Date Entered

Santa Clara County Office of Education

STUDENT CERTIFICATION

DENTAL, VISION AND EMPLOYEE ASSISTANCE PROGRAM

Required for all dependents 19 – 25 years of age

To be eligible, the dependent must be:

- Full-time student in an accredited institution (12 units)
- Dependent upon employee for support
- Unmarried
- Under 25 years of age

_____ _____
Dependent Name PRINT Date of Birth

_____ _____
Social Security Number Student I.D. Number

_____ _____
School Name PRINT School Address City, State, Zip

(_____)_____ www._____
School Telephone # and Website

I certify that the dependent shown above meets all of the requirements for coverage on my account as a full-time student. I understand that all medical plans for this dependent will terminate on the first day of the month following the date that any one of these requirements is no longer met.

_____ XXX-XX-_____
Employee Name - PRINT SS# Last 4 Digits

_____ _____ _____
Employee Signature Date Telephone (Home, Cell or Work)

Return form to Human Resources, 1290 Ridder Park Drive, San Jose, CA, 95131 or fax or email to:

Employee Benefits Specialist	Last name beginning	Phone number	Fax number	email
Tina Cordoba	A-G	(408) 453-6831	(408) 453-3660	tina_cordoba@sccoe.org
Loraine Hobgood	H-O	(408) 453-4355	(408) 453-3658	loraine_hobgood@sccoe.org
Patty Tijerina	P-Z	(408) 453-6681	(408) 453-3659	patty_tijerina@sccoe.org

Vitality

Santa Clara County Office of Education

Jon R. Gundry
County Superintendent of Schools

Complete the Vitality Health Review (VHR) and reactivate your Vitality account.

SCCOE rewards staff who participate in Vitality and commit to keeping well.

Vitality Points and Status can earn you gift cards, fitness devices, a gym subsidy, wellness rebates, and a Flexible Spending Account (FSA) up to $400.

Here's what you can do to start off the new program year right:

1. Log on to Vitality at PowerofVitality.com or download the Vitality Today app
2. Complete the VHR and earn 500 points
3. Navigate to the Points Planner and plan your personal pathway to better health

BONUS! Earn 250 bonus points when you complete the VHR by 9 p.m. on November 30, 2016.

New to Vitality? Click the ***Register now*** link to open an account. Use your employee ID number and legal first and last name.

Log on to PowerofVitality.com for complete Vitality program details.

Questions? Email Tricia_Zamora@SCCOE.org or call (408) 453-3616.

Privacy is a top priority at Vitality. Vitality is committed to maintaining the highest level of confidentiality with all of the information received from members. The Vitality program is designed to benefit every age, every type, and every level of condition.

Human Resources Branch, Talent Management

Santa Clara County Office of Education

Section 125 Benefit Enrollment

Plan Year: 10/01/2016- 9/30/2017

Enrollment Schedule

Site	Date	Time
Hester School 1460 The Alameda, San Jose 95126	**August 22nd**	**8:00-4:00**
Ann Darling School 1559 Marburg Way, San Jose 95133	**August 23rd**	**8:00-4:00**
Chandler Tripp School 780 Thornton Way, San Jose 95128	**August 24th**	**8:00-4:00**
Oster School 1854 Nelson Way, San Jose CA 95124	**August 30th**	**8:00-4:00**
McCollam Cluster Annex 550 Gridley Street, San Jose 95127	**August 31st**	**8:00-4:00**
SCCOE-Human Resources Conference Room 1290 Ridder Park Drive, San Jose 95131	**September 16th** **September 19th** **September 20th** **September 21st**	**8:00-4:00**
Gateway School 7151 Hanna Street, Gilroy 95020	**September 22nd**	**8:00-4:00**

PLEASE READ:

Please meet with your American Fidelity Representative to learn more about your benefits offered through payroll deduction.

IMPORTANT: For those employees who wish to enroll, continue or make changes to your Medical Reimbursement or Dependent Day Care Account for the next plan year, you must meet with your American Fidelity Representative.

Please contact American Fidelity to make an appointment:

1-866-504-0010 x0

AMERICAN FIDELITY

a different opinion

Anthem Blue Cross and Kaiser High Deductible Health Plans and Health Savings Account Information

The Santa Clara County Office of Education offers two high deductible health plans. One through Anthem Blue Cross and the other through Kaiser. These plans are the least expensive plans the SCCOE offers and allows for the opportunity to open a Health Savings Account.

What is a High Deductible Health Plan (HDHP)? An HDHP is a health plan where you must pay an annual deductible before your benefits will pay. Once you meet the deductible, you will be responsible for copays and coinsurances up until the maximum out of pocket amount is reached. You also have the option of opening a pre-tax based Health Savings Account (HSA) to pay for your qualified medical, dental and vision expenses.

What is a Health Savings Account (HSA)?
A Health Savings Account (HSA) is a special tax-advantaged account owned by an individual that is used to pay for current and future Qualified Medical Expenses. It must be used in conjunction with a High Deductible Health Plan, such as the HSA Qualified Deductible plans offered through Anthem Blue Cross or Kaiser. If you choose to open an account through the SCCOE's preferred vendor, you will have pre-tax payroll deductions applied directly to your HSA. You may also choose to open an account through an institution of your choosing, contribute after-tax dollars, and claim a deduction at the end of the year.

How does an HSA work?

- Money goes into the account pre-tax and comes out "tax-free" for qualified medical expenses. This can be made from pre-tax deductions from your paycheck. You may also make post-tax contributions directly into the account and take the deduction when you file your taxes.
- Unused money in the account continues to roll over year after year and can earn interest—unlike the "use it or lose it" rule that the Flexible Spending Accounts must abide by.
- Upon turning age 65, you can use any unused funds in the account for any purpose, penalty free, but subject to ordinary income tax.
- HSAs encourage individuals to take a more proactive approach to their own healthcare, by learning to make informed choices about their health care.

What happens to my Health Savings Account if I leave or change plans?

You will not lose your account. If you change employers and enroll in another HDHP, you may roll over your money from one account to another. If you are unable to enroll in another HDHP, you may not make any contributions, but you can spend it down or leave it to earn interest.

How much can I contribute to my account?
This plan is regulated by the IRS. The maximum amount that may be contributed (and deducted) to the account from all sources for 2016 is $3,350 for individual coverage and $6,750 for family coverage. The maximum amount that may be contributed (and deducted) to the account from all sources for 2017 is $3,400 for individual coverage and $6,750 for family coverage. Contributions in excess of the contribution limits must be withdrawn by the individual or will be subject to ordinary income tax.

To find out more about enrolling in the Anthem Blue Cross or Kaiser High Deductible Health Plan, or opening an HSA, please contact your Employee Benefits Specialist.

Medicare Part D Notice

Important Notice from Santa Clara County Office of Education (SCCOE) 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 Office of Education (SCCOE) 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 Office of Education (SCCOE) has determined that the prescription drug coverage offered by the SCCOE plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your Santa Clara County Office of Education (SCCOE) coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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

If you do decide to join a Medicare drug plan and drop your Santa Clara County Office of Education (SCCOE) prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Santa Clara County Office of Education (SCCOE) 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 Office of Education (SCCOE) changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	7/25/2016
Name of Entity/Sender:	Santa Clara County Office of Education (SCCOE)
Contact-Position/Office:	Candice Harris, Director – Human Resources
Address:	1290 Ridder Park Drive, San Jose, CA 95131-2304
Phone Number:	(408) 453-6876

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For further details, please refer to the Plan's Summary Plan Description.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Notice of Special Enrollment Rights

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

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request [medical plan OR health plan] enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Santa Clara County Office of Education (SCCOE) medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another medical plan OR health plan]. [Optional – not required under HIPAA but might be required by a carrier in order for the dependent to remain eligible for coverage under a plan option. If applicable, add: Any other currently covered dependents may also switch to the new plan in which you enroll.]

Notice of Choice of Providers

The Kaiser Permanente plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Kaiser Permanente at 800-464-4000.

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

You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Kaiser Permanente at 800-464-4000.

Michelle's Law

The Santa Clara County Office of Education (SCCOE) plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify your benefit specialist as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Save the Date!

SCCOE Staff Wellness Event

Saturday, Sept. 17, 2016
9 a.m. to 12:30 p.m.
Ridder Park

Nourish your mind and body while earning thousands of Vitality Points. Enjoy a complimentary health screening, flu shot, cooking demos, fitness classes and more!

Registration opens August 15

Questions?

Email Tricia_Zamora@sccoe.org or call (408) 453-3616.

Event services and prizes compliments of community partners.

Santa Clara County Office of Education

Jon R. Gundry, County Superintendent of Schools

Human Resources Branch/Talent Management

Notes

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Santa Clara County
Office of Education
1290 Ridder Park Drive
San Jose, CA 95131-2304

Santa Clara County Office of Education
www.sccoe.org