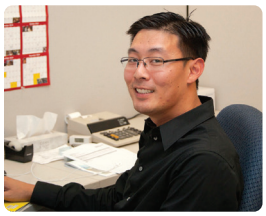
Santa Clara County Office of Education

URGENT

MEDICAL PLAN INFORMATION

OPEN ENROLLMENT DEADLINE

AUGUST 21, 2015






Vitality

Santa Clara County Office of Education

Jon R. Gundry
County Superintendent of Schools

It's time for: **Current members to renew and take the Vitality Health Review (VHR)**
New members to register and take the VHR

SCCOE staff who participate in Vitality enjoy:

- ☆ Motivation to improve well-being
- ☆ Up to $400 towards a Flexible Spending Account
- ☆ Gym subsidies and wellness rebates
- ☆ Using Vitality Points to purchase fitness devices

The Vitality program is a free benefit for all regular SCCOE staff and benefits every age, every body type, and every level of condition.

Take the Vitality Health Review to get started!

1. **Register or log in**
2. **Take your VHR**
3. **Review Vitality goals and complete activities that improve health**

Complete the VHR from Sept. 1 to Nov. 30 and earn 250 bonus points!

Log on to the Vitality website, www.PowerofVitality.com, for complete Vitality program details.

Questions regarding SCCOE Wellness? Contact Tricia Zamora, Employee Wellness Specialist at Tricia_Zamora@SCCOE.org or (408) 453-3616.

Human Resources Branch, Talent Management

Table of Contents

Letter to Employees....1

To Do List....2

Plan Election Form....3

Medical Plan Cost....4

Plan Comparison Chart....6

Anthem Instructions....8

Anthem Application....9

Kaiser Instructions....10

Kaiser ApplicationForm....11

Dental/Vision Enrollment Form....12

Student Certification....15

Health Savings Account Information....16

Important Notice About Your Prescription Drug Coverage and Medicare....18

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)....20

Women's Health and Cancer Rights Act....20

Michelle's Law Notice....20

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)....21

New Health Insurance Marketplace Coverage Options....25

This page intentionally left blank.

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

July 31, 2015

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 2015 Open Enrollment period (August 10-August 21). To help in this process, we have highlighted some plan changes:

- The Anthem HDHP-Select Network plan will no longer be available. The Anthem HDHP-Full Network plan will still be offered.
- The deductible amount for the Anthem HDHP-Full Network plan has increased to $3000/$5000.
- A Kaiser HDHP plan has been added.
- Chiropractic and acupuncture benefits will now be offered to Kaiser HMO and Kaiser DHMO members through the American Specialty Health (ASH) network.

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, 2015, 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 21, 2015. 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 12, 2015	1:00-6:00 p.m.	SCCOE-Oak Grove room 1290 Ridder Park, San Jose
August 14, 2015	12:30-6:00 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 21, 2015.**

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
Sheri Meyers	P-Z	(408) 453-6681	(408) 453-3659	sheri_meyers@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
Earl Thaxton	ACE/CTA	earl_thaxton@sccoe.org
Karyn Kikuta	ACE/CTA	karyn_kikuta@sccoe.org
Lisa Vieler	ACE/CTA	livelier@aol.com
Dana Jensen	ACT/CTA	dana_jensen@sccoe.org
Lee Alvis	SEIU, Worksite Organizer	lee.Alvis@seiu521.org
Sandy Fakaosi	SEIU – Paraeducators	sandra_fakaosi@sccoe.org
Farida Kuraishy	Psychologists/Social Workers	farida_kuraishy@sccoe.org
Craig Blackburn	Leadership Team	craig_blackburn@sccoe.org
Kolvira Chheng	Leadership Team	kolvira_chheng@sccoe.org
Barbara Coats	Risk Management - Resource	barbara_coats@sccoe.org
Tina Cordoba	Employee Benefits Specialist - Resource	tina_cordoba@sccoe.org
Loraine Hobgood	Employee Benefits Specialist - Resource	loraine_hobgood@sccoe.org
Sheri Meyers	Employee Benefits Specialist - Resource	sheri_meyers@sccoe.org

Santa Clara County Office of Education

Plan Election Form (Required for all medical plan changes and new enrollments)

Effective October 1, 2015, employees have the option to choose between three (3) PPO plans and three (3) Kaiser HMO plan packages. Your choices are listed below. Please make your choice by checking the box and initialing under the plan you wish to enroll.

Employee Classification: ☐ Classified ☐ Certificated ☐ Leadership Team

	Kaiser HMO $30 OV, Rx $10-$30 (100 days)	**Anthem PPO (Full Network)** $20 OV, Rx $5-$20
Plan Offerings:		
Individual/Family Deductible(s):	No Deductible	No Deductible
Out of Pocket Maximum (OOP)	$1,500/$3,000	$2,000/$4,000
Doctor Visits:	$30 co-pay	$20 co-pay
X-Ray and Lab:	No co-pay	No co-pay
Hospital	No co-pay	No co-pay
12-month payroll deduction		
Part-time 5.5 hrs/day	$614.85	$860.85
Full-time	$551.84	$797.84
	☐ Initial	☐ Initial

	Kaiser DHMO $20 OV, Rx $10-$30 (30 days)	**Anthem PPO (Select Network)** $20 OV, Rx $5-$20
Plan Offerings:		
Individual/Family Deductible(s):	$1,000/$2,000	No Deductible
Out of Pocket Maximum (OOP)	$3,000 / $6,000	$2,000/$4,000
Doctor Visits:	$20 co-pay (Ded waived)	$20 co-pay
X-Ray and Lab:	$10/$50 (Ded waived)	No co-pay
Hospital	20% After deductible	No co-pay
12-month payroll deduction		
Part-time 5.5 hrs/day	$150.85	$708.85
Full-time	$87.84	$645.84
	☐ Initial	☐ Initial

	Kaiser HDHP (HSA QUALIFYING)	**Anthem HDHP (Full Network)** (HSA QUALIFYING)
Plan Offerings:		
Individual/Family Deductible(s):	$1,500/$3,000	$3,000/$5,000
Out of Pocket Maximum (OOP)	$3,000/$6,000	$5,000/$10,000
Doctor Visits:	10% After Deductible	10% After Deductible
X-Ray and Lab:	10% After Deductible	10% After Deductible
Hospital	10% After Deductible	10% After Deductible
12-month payroll deduction		
Part-time 5.5 hrs/day	$59.58	$93.85
Full-time	$0	$30.84
	☐ Initial	☐ Initial

I understand that the only time that I may change to another plan is during SCCOE's designated Open Enrollment Period for an effective date of October 1. If I gain a new dependent (i.e. marriage, birth or adoption), I can add those dependents by completing a change form, but I cannot change from one plan to another at anytime except during the Open Enrollment Period for an effective date of October 1.

I further understand that the plan I choose may require a payroll deduction and the premium will be deducted from my check.

***Premiums stated are for 12-month employees. Premiums will be prorated for 10 and 11 month employees.**

PRINT YOUR NAME CLEARLY _____ **SIGNATURE** _____ **DATE** _____

DUE DATE: August 21, 2015

Please return this form, your medical enrollment form and required legal documents to Human Resources.

Medical Plan Cost

Kaiser HMO will cost **$19,224.00** 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)	$1,602.00	$987.15	$614.85	$670.75	$737.82
Full-time	$1,602.00	$1,050.16	$551.84	$602.01	$662.21

Kaiser Deductible DHMO will cost **$13,656.00** 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)	$1,138.00	$987.15	$150.85	$164.56	$181.02
Full-time	$1,138.00	$1,050.16	$87.84	$95.83	$105.41

NEW PLAN FOR 2015/2016

Kaiser High Deductible Health Plan (HDHP) with Health Savings Account (HSA) option will cost **$11,916.00** per year. See additional information enclosed in this booklet regarding this plan and an opportunity to open a tax-differed Health Savings Account (HSA).

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)	$993.00	$933.42	$59.58	$65.00	$71.50
Full-time	$993.00	$993.00	$0	$0	$0

Anthem PPO (Full Network) will cost **$22,176.00** 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)	$1,848.00	$987.15	$860.85	$939.11	$1,033.02
Full-time	$1,848.00	$1,050.16	$797.84	$870.37	$957.41

Anthem PPO (Select Network) will cost **$20,352.00** per year. To locate a doctor in the Select Network go to www.anthem.com/ca/SISC.

Anthem PPO (Select 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)	$1,696.00	$987.15	$708.85	$773.29	$850.62
Full-time	$1,696.00	$1,050.16	$645.84	$704.55	$775.01

Anthem PPO High Deductible Health Plan (HDHP) with Health Savings Account (HSA) option will cost **$12,972.00** per year. See additional information enclosed in this booklet regarding this plan and an opportunity to open a tax-differed Health Savings Account (HSA). To locate a doctor go to www.anthem.com/ca/SISC.

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)	$1,081.00	$987.15	$93.85	$102.38	$112.62
Full-time	$1,081.00	$1,050.16	$30.84	$33.64	$37.01

Delta Dental of California will cost **$1,701.24** 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)	$141.77	$133.26	$8.51	$9.28	$10.21
Full-time	$141.77	$141.77	$0	$0	$0

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

SISC Plan Name	Anthem PPO 100-A $20, Rx 5-20	Anthem HDHP-HSA-Plan B HSA Compatible Plan
CLASSIFIED Active Group Number	40428A Full or 40428B Select	40428C Full
CERTIFICATED Active Group Number	40449A Full or 40449B Select	40449C Full
MANAGEMENT Active Group Number	40456A Full or 40456B Select	40456C Full
Provider Network(s): **Hospital & Professional**	**Available in Full Prudent Buyer Network or Anthem Select PPO Network***	**Available in Full Prudent Buyer Network Only**
Calendar Year Deductible(s) *The deductible is the amount member pays before the Plan starts to at benefit level.*	**No deductible**	**$3,000** per individual up to **$5,000** per family
Calendar Year Out of Pocket Maximum	**$2,000** per individual up to **$4,000** 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.	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**
Office Visits (co-pays will apply to Out-of-Pocket maximum)	$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%
Outpatient Laboratory and X-Ray	No co-pay	10% after deductible
Inpatient Hospital & Ambulatory Surgery Ctr Room, Board & Support Services (prior authorization required)	No co-pay	10% after deductible
Emergency Room/Accident Care (within 48 hrs)	$100 co-pay, waived if admitted	$100 co-pay, waived if admitted
Facility & Provessional Expenses: *medical emergencies as defined by the Plan	No co-pay	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	10% after deductible
Acupuncture (12 visits per year)	No co-pay up to 12 visits	10% after deductible
Psychiatric & Substance Abuse Inpatient	No co-pay	10% after deductible
Outpatient	$20 co-pay	10% after deductible

Outpatient Prescription Drugs	SISC Rx Plan 5-20		Anthem Rx Plan (Express Scripts)	
	Retail 30-day supply	**Costco Retail or Mail** 90-day supply	**Retail** 30-day supply	**Mail** 90-day supply
Most Generic Drugs	$5	$0	$7	$14
Single Source Brand Name Drugs	$20	$50	$25	$60
Multi Source Brand Name Drugs	$5 + brand/generic cost difference	$15 + brand/generic cost difference	$25	$60
Brand Only - Calendar Year Deductible	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/ $3,000 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.

*** Please refer to the Anthem PPO Directory for confirmation on providers in the full Network verses the Select PPO Network.**

Santa Clara County Office of Education
SISC Anthem Blue Cross PPO and Kaiser Plans - A Brief Comparison
Effective October 1, 2015

Kaiser $30 OV, Rx $10-30 (100-days)	Kaiser DHMO $20 OV, Rx $10-30 (30-day)	Kaiser HDHP-HSA-Plan A HSA Compatible Plan
604352-0039 604352-0040 604352-0041	604352-0042 604352-0043 604352-0044	New group number New group number New group number
Kaiser	**Kaiser**	**Kaiser**
No deductible	**$1,000** per individual up to **$2,000** per family	**$1,500** per individual up to **$3,000** per family
$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
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
Participating In-network Providers	**Participating In-network Providers**	**Participating In-network Providers**
$30 co-pay	Deductible Waived, $20 co-pay	10% after deductible
No co-pay	Deductible Waived, 100%	Deductible Waived, 100%
No co-pay	Deductible Waived Complex imaging: $50; all other $10	10% after deductible
No co-pay	20% after deductible	10% after deductible
$100 co-pay, waived if admitted No co-pay	20% after deductible	10% after deductible
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.
$10 co-pay (chiro/acupuncture combined)	$10 co-pay (chiro/acupuncture combined)	10% after deductible
No co-pay	20% after deductible	10% after deductible
$30 co-pay	Deductible Waived, $20 co-pay	10% after deductible

Kaiser Rx Plan 10-30		Kaiser Rx Plan 10-30		Kaiser Rx Plan (copays after ded)	
Kaiser Pharamcy 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
$10 $30	$10 $30	$10 $30	$20 $60	$10 $30	$20 $60
$30	$30	$30	$60	$30	$60
Not applicable		Not applicable		**Subject to medical deductible. Co-pays only apply after the medical deductible has been met.**	
Included in Medical OOP Maximum		Included in Medical OOP Maximum		Included in Medical OOP Maximum	

NOTE: Eff 10-1-2015, Anthem will no longer pay for out-of-network X-ray, Lab, DME or Physical Medicine (Chiro or PT) and In-patient Hip, Knee or Spine procedures will require the use of the Anthem Blue Distinction Plus Network. For Kaiser, there is not coverage when accessing benefits from a non-Kaiser provider without a referral. Patient will have greater out-of-pocket expenses when using a non-participating or non-contracting provider.

ANTHEM – INSTRUCTIONS FOR COMPLETING THE SISC III ENROLLMENT FORM

1. Designate your plan selection at the top of the form: “HSA” or “PPO”.
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. Make sure you have completed The Plan Election Form.
7. Submit the completed paperwork no later than August 21, 2015.

❑ HSA ❑ PPO

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: 10/01/2015 HIRE DATE: N/A 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		

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

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?
		N/A	N/A	☐ 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)
TOTALLY DISABLED? ☐ YES ☐ NO

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)

ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH / /	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH / /	TOTALLY DISABLED? ☐ YES ☐NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH / /	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH / /	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ 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. Complete your personal information in section B ensuring that every field is complete (MRNs are not necessary).
2. Complete personal information for any dependents enrolling on the plan into section C of the form (MRNs not necessary).
3. Sign and date your completed form.
4. 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
5. Make sure you have completed The Plan Election Form.
6. Submit your completed paperwork no later than August 21, 2015.

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) N/A
Medical Group Number:	Enrollment Unit:	Effective Enrollment/ Change Date (mm/dd/yyyy) 10/01/2015

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.*

KAISER PERMANENTE®

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

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 #1				☐ **Y** ☐ **N**
DEPENDENT #2				☐ **Y** ☐ **N**
DEPENDENT #3				☐ **Y** ☐ **N**
DEPENDENT #4				☐ **Y** ☐ **N**
DEPENDENT #5				☐ **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 <u>not to participate</u> 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.

I understand that I am being offered the opportunity to enroll in affordable, comprehensive health insurance coverage through my employment with the Santa Clara County Office of Education. I understand that as of January 1, 2014, I am required by law to maintain an acceptable level of health insurance coverage for myself and my dependents.

WAIVER OF COVERAGE AGREEMENT:

By signing this form I have agreed to waive my employer-paid benefits. I understand that unless I experience a qualifying event as defined by the IRS, I will not be allowed to enroll in coverage or make changes to my selection until the next open enrollment period.

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

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)

Health Savings Account (HSA)

Helping you get more for every healthcare dollar

What is an HSA?

A Wells Fargo HSA is like an IRA for your healthcare that empowers you to prepare for and manage healthcare costs. HSAs offer triple tax benefits, including tax-free[1] saving, growth, and spending on qualified medical expenses anytime, from today throughout your retirement — something you can't get from other retirement accounts. HSAs complement your retirement plan, helping you prepare for the $250,000[2] or more that you will need for retirement medical expenses. HSAs can also be used to save and pay tax-free today for your healthcare expenses — from doctor's visits to prescriptions, as well as dental and vision expenses.

More than 15,000,000 people[3] have enrolled in an HSA. Here's why:

HSAs can put extra money in your pocket

- HSA-qualified health insurance premiums are typically lower than other health insurance plans.
- If your premiums are lower, you can contribute the savings to your HSA — it's like earning extra income, and it's saved in an account that is yours to keep.

HSAs typically offer more benefits than FSAs

- Each offers tax-free contributions and spending on qualified medical expenses.
- Higher annual limits for contributions[4] mean more family tax savings potential with HSAs.
- HSA funds are yours to keep even if you don't use them, and carry forward year after year.

HSAs are like IRAs for your healthcare

- You can use your HSA to save for healthcare expenses in retirement.
- You won't be taxed, even after you retire, as long as you use the money in your HSA for qualified medical expenses.

HSAs offer the potential for investment growth

- You can invest in a broad range of HSA Mutual Funds.[5]
- Any investment gains you make are tax-free.
- Wells Fargo offers tools to help you research, manage, and optimize your investment opportunities.

Benefit from tax savings

The money you contribute to your HSA is tax-free[1] and can be used to pay for qualified medical expenses for you, your spouse, and your tax dependents.

These tax savings can allow you to save up to $25 or more for every $100 contributed to your HSA.[6]

Income tax savings

	Without an HSA	With an HSA
Income	$1,000	$1,000
HSA contribution	$0	$1,000
25% federal income tax[6]	-$250	$0
Money to spend on qualified medical expenses	$750	$1,000

Together we'll go far

2015 HSA contribution limits

The maximum amount the IRS allows you to contribute to your HSA in 2015 is $3,350 for individual coverage and $6,650 for family coverage.[7] Plus, if you are aged 55 or older, you can contribute an additional catch-up contribution of $1,000.

Check with your employer to see if you can contribute to your HSA with before-tax payroll deductions. Or, you can make contributions to your HSA up to the annual IRS contribution limits on an after-tax basis and deduct them from your return.

Convenient payment options

With a swipe of your *Wells Fargo Visa*® HSA debit card, you can pay for prescriptions, doctor's visits, dental expenses, hearing aids, eyeglasses, and more. Each time you use your HSA debit card, expenses are automatically deducted from your HSA.

You can also make withdrawals from your HSA by visiting any Wells Fargo store or Wells Fargo ATM.

Easy account management tools

Access your HSA online through *Wells Fargo Online*® Banking by going to wellsfargo.com. Click on your HSA balance to access the *Health Account Manager*℠ portal to view transaction history, order debit cards for your spouse and dependents, activate your investment account, and choose to receive online statements.

HSAs offer the potential for investment growth

The average couple retiring today may need up to $250,000 for medical expenses in retirement.[2] Wells Fargo is here to help you understand and prepare for those expenses.

Once you reach a minimum balance in your FDIC-insured deposit account, you have the option to invest in a diverse range of HSA Mutual Funds. It's easy to find funds that meet a variety of long-term investment strategies. Tools are available to help you research, manage, and optimize your investment opportunities at our HSA Investment Center. And, through our relationship with *Wells Fargo Advantage Funds*®,[8] investment professionals are available to assist you.[9]

Getting started is easy

Once you've enrolled in an HSA-qualified health plan, it's easy to set up your Wells Fargo HSA. Simply follow the instructions specific to your employer's benefits enrollment process.

Shortly after opening your account, you'll receive a welcome package in the mail. This packet includes all the information you need to start managing your HSA. Within a few days of receiving the welcome package, you'll receive your HSA debit card in a separate mailing, with instructions for using the card.

How can we help?

To learn more about maximizing the value of your HSA, or if you have questions about your HSA, call the HSA Customer Service team at 1-866-884-7374, Monday through Friday, from 7:00 a.m. to 8:00 p.m. Central Time.

---

[1] HSA contributions up to annual contribution limits are not subject to federal income tax. State taxes vary. Please consult a tax advisor for more information.

[2] Individual situations may vary and not all costs may qualify for reimbursement from an HSA. Source: Anthony Webb and Natalia Zhivan, "How Much is Enough? The Distribution of Lifetime Health Care Costs," Center for Retirement Research at Boston College (February 2010).

[3] America's Health Insurance Plans, Center for Policy and Research (May 2012).

[4] This is generally true if an individual is HSA-eligible for the full tax year. FSA salary reduction contributions are limited to $2,500 per employee in 2015.

[5] **INVESTMENT PRODUCTS: NOT FDIC-INSURED • NO BANK GUARANTEE • MAY LOSE VALUE**

[6] This example is for illustrative purposes only. Savings may vary based on the tax bracket. HSA contributions up to annual contribution limits are not subject to federal income tax. State taxes vary, and some states do not recognize HSAs. Please consult a tax advisor for more information.

[7] Personal limits may be lower than IRS maximums. Consult your tax advisor with questions.

[8] Mutual fund investing involves risks, including the possible loss of principal. Consult a fund's prospectus for additional information on risks. Carefully consider a fund's investment objectives, risks, charges, and expenses before investing. For a current prospectus and, if available, a summary prospectus, containing this and other information, visit wellsfargoadvantagefunds.com. Read it carefully before investing.

[9] The funds are distributed by Wells Fargo Funds Distributor, LLC, member FINRA/SIPC, an affiliate of Wells Fargo & Company (August 2012).

wellsfargo.com/hsa

Important Notice
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 The 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 Santa Clara County Office of Education (SCCOE) 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 are 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…

For further information, contact the Santa Clara County Office of Education (SCCOE) Human Resources Department.

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 www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	August 10, 2015
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

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act ("WHCRA") requires Santa Clara County Office of Education (SCCOE) to notify participants and beneficiaries of Santa Clara County Office of Education (SCCOE) Group Health Plan (the "Plan"), of their rights to mastectomy benefits under the Plan. Participants and beneficiaries have rights to coverage to be provided in a manner determined in consultation with the attending Physician 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 are subject to the same deductible and co-payments applicable to other medical and surgical benefits provided under this Plan. For further details, please refer to the Plan's Summary Plan Description.

Michelle's Law Notice — Extended dependent medical coverage during student medical leaves

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, contact your benefits specialist as soon as the need for the leave is recognized to Santa Clara County Office of Education (SCCOE). In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100

MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473

TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

New Health Insurance Marketplace Coverage Options

Part A: General Information

Health care reform created a new way to buy private individual health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage we offer to you. Please note that this notice is informational only.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find private individual health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 15, 2014 for coverage starting January 1, 2015.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does the Employment-Based Health Coverage We Offer to You Affect Your Eligibility for Premium Savings through the Marketplace?

Yes. If we have offered you health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and you may wish to enroll in our health plan, if you are eligible. (Just because you received this Marketplace notice does not mean you are eligible.) However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if we do not offer coverage to you at all or do not offer coverage that meets certain standards. If the cost of self-only coverage under our health plan is more than 9.5% of your household income for the year, or if our health plan does not meet the "minimum value"[1] standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution—as well as your employee contribution—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information About the Health Insurance Marketplace?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Part B: Information About Employer-Provided Health Plan Coverage

If you decide to complete an application for coverage in the Marketplace, you will be asked for information about our health plan coverage. The information below can help you complete your application for coverage in the Marketplace.

1. General Employer Information.

Employer name:	Santa Clara County Office of Education (SCCOE)
Employer Identification Number (EIN):	94-6020929
Employer street address:	1290 Ridder Park Drive
Employer phone number:	(408) 453-6500
Employer city:	San Jose
Employer state:	California
Employer ZIP code:	95131-2304
Who can we contact about employee health coverage at this job?:	Human Resources
Phone number (if different from above):	
Email address:	tina_cordoba@sccoe.org(A-G) loraine_hobgood@sccoe.org(H-O) sheri_meyers@sccoe.org(P-Z)

2. Eligibility. You may be asked whether or not you are currently eligible for our health plan coverage or whether you will become eligible for coverage within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting Human Resources.

3. Minimum Value. If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.

4. Premium Cost. If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.

If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact Human Resources.

5. Future Changes. You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, you will be provided with information about any changes to our health plan coverage before the next open enrollment period. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.

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

SCCOE Staff Wellness Event

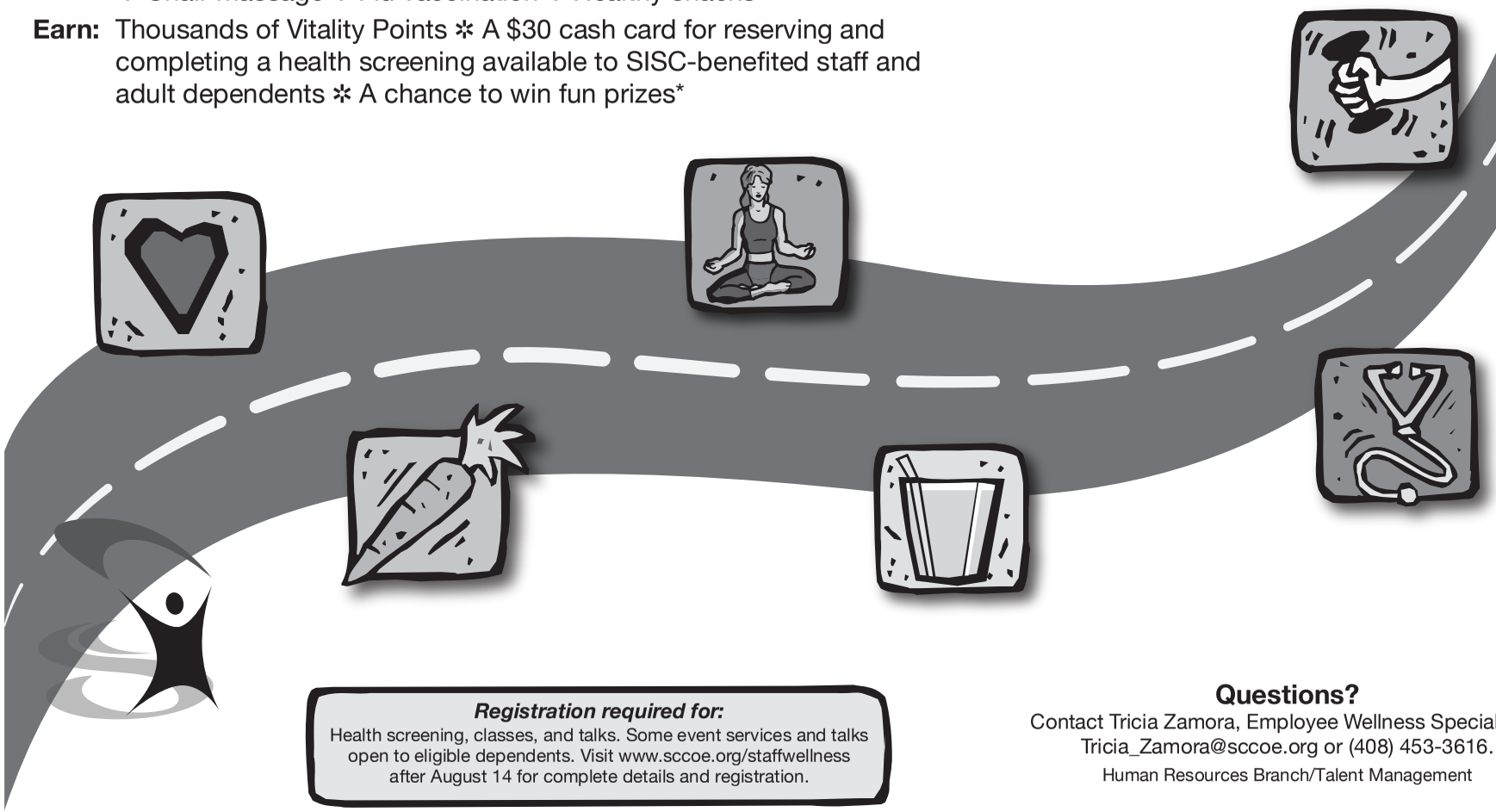
Vitality

HIGHWAY TO HEALTH

Saturday, September 19, 2015
9 a.m. to 12 noon
Ridder Park

Enjoy complimentary: Health screening ✲ Wellness talks ✲ Fitness classes ✲ Chair massage ✲ Flu vaccination ✲ Healthy snacks

Earn: Thousands of Vitality Points ✲ A $30 cash card for reserving and completing a health screening available to SISC-benefited staff and adult dependents ✲ A chance to win fun prizes*



Registration required for:
Health screening, classes, and talks. Some event services and talks open to eligible dependents. Visit www.sccoe.org/staffwellness after August 14 for complete details and registration.

Questions?
Contact Tricia Zamora, Employee Wellness Specialist at Tricia_Zamora@sccoe.org or (408) 453-3616.
Human Resources Branch/Talent Management

*Event services and prizes compliments of Self Insured Schools of California (SISC) and community partners.

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

A Human Resources Branch Publication

Santa Clara County Office of Education

www.sccoe.org