



2025-2026

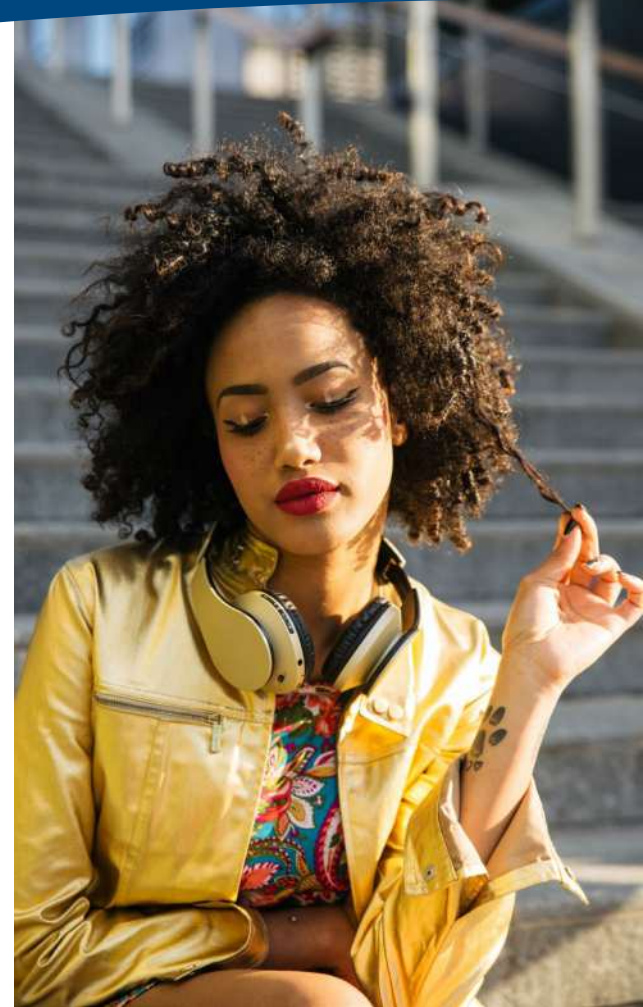
Faculty Benefits

Invest in Yourself



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MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.



Welcome to Your Benefits Guide

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Santa Clarita Community College District (SCCCD) supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

Dental, Vision and Life benefits are effective October 1, 2025, through September 30, 2026

CalPERS Medical benefits are effective January 1, 2026, through December 31, 2026

IMPORTANT NOTE: This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail.

Who is Eligible?

Full-time Faculty are eligible to enroll themselves and their eligible dependent in benefits outlined in this overview.

The following dependents are eligible for benefits:

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit. Review the Affidavit carefully because it will include important information regarding the guidelines for adding, ending or changing your domestic partner.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

Members who are NOT eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.



When you can enroll

New Hire Enrollment	New hire coverage begins on first of the month following your date of hire. You must enroll within 30 days of becoming eligible.
Open Enrollment	The one time each year that you can make changes to your benefits for any reason. Open enrollment is generally held in August every year for an October 1 effective date for dental, vision and life insurance. CalPERS medical enrollment is generally held in September for coverage effective January 1.
Qualifying Life Event	A qualifying life event is a significant change in your life that allows you to make changes to your benefits outside of open enrollment. See the next page for more information.

Changing Your Benefits

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

Any change you make must be consistent with the change in status. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

You must submit your change within 30 days (dental, vision, life) or 60 days (medical) after the event.

Dependent Verification

Making changes to dependents is subject to eligibility. You will be required to provide proof of one or more of the following within 30 days (dental, vision, life)/60 days (medical) of their eligibility:

- Marriage Certification or License
- Domestic Partners Affidavit
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period (dental, vision, life) or 60-day period (medical), you will not be able to add the dependent(s) until the next open enrollment period.

CalPERS Medical Benefits

It is Santa Clarita Community College District's goal to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. Santa Clarita Community College District offers a choice of medical plans through CalPERS Medical.

For a summary of the different plans, and additional information please review the CalPERS Open Enrollment site: calpers.ca.gov/page/active-members/health-benefits/open-enrollment. On this site you will find the Health Benefits Summary, Health Program Guide, additional resources and information regarding your CalPERS Health Plan options.

Why would I choose a PPO plan?

- You have a doctor you like, and you would like to keep this doctor.
- You want to see specialists and other providers without having to first get a referral and/or pre-approval.
- You want the freedom to see providers who are not in the network.
- You are confident that you can manage your own care.
- You do not want a primary care doctor.

Why would I choose an HMO plan?

- You don't want the extra responsibility of managing your own care.
- You do not want to pay the higher costs of a PPO.
- You do not want to get bills from providers.

Explore your benefits with myCalPERS

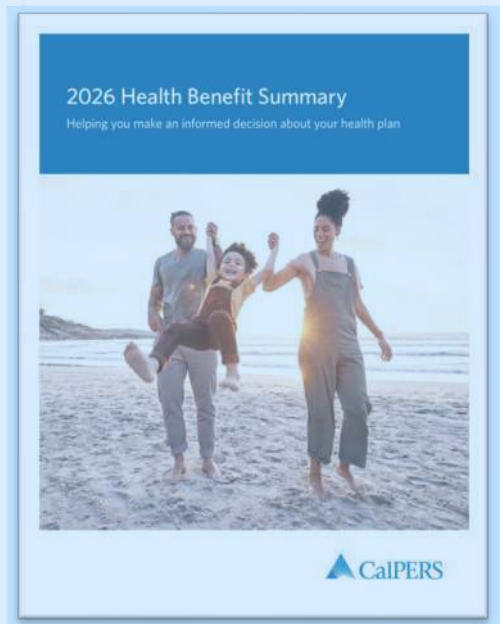
Access your health information year-round, including available health plans and Open Enrollment updates, by logging in to myCalPERS at my.calpers.ca.gov. To find CalPERS health plans available in your area, search by zip code at calpers.ca.gov.

Enrolling In CalPERS Plans

All enrollments should be processed through [Benefit Bridge](#), not the CalPERS website.

Health Benefit Summary

Click the image below to view the [2026 CalPERS Health Benefit Summary](#).



CalPERS Dependent Eligibility Verification

All employees adding/removing dependents must submit documentation to verify their dependent's eligibility and/or Qualifying Life Event. The following chart is an easy guide to what documents must be submitted along with the Health Enrollment/Change form.

	Enrollment Form Required	Marriage Certificate Required	State of California Domestic Partner (DP) Registration	Birth Certificate /Certificate of Adoption Required	Social Security Number
Employee only	●				
Employee & Spouse	●	●			●
Employee & Domestic Partner (DP)	●		●		●
Employee & Children	●			●	●
Employee, Spouse/DP & Children	●	●	●	●	●

You are responsible for ensuring that the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or health care services incurred during the entire ineligibility period.

For example, if your divorce or dissolution occurred in 2018, yet you did not report it until 2021, your former spouse or domestic partner will be retroactively canceled from coverage effective the first of the month following the divorce or dissolution.

On page 8, you will find a detailed list of Qualifying Life Events, which must be reported to the HR Department so we can make the appropriate change to your health coverage. All Qualifying Life Event changes must be made within 60 days from the date of the event. Proper documentation is required, such as a copy of the marriage/domestic partnership certificate, birth/adoption certificate, or divorce/dissolution of domestic partnership decree.

For further clarification, please contact Human Resources at (611) 362-3427.

Prescriptions Breaking Your Budget?

Understanding the formulary can save you money

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

What is a formulary?

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

Get the most from your coverage

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

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



The Formulary Drug Tiers Determine Your Cost

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

Click to play video



Prescription Drugs

Learn about the best life hacks to help you save when it comes to prescription drug shopping.

Know Where To Go

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

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

Click to play video



Urgent Care vs ER

ER visits should only be used for very serious medical issues. The cost per visit will be much higher than the other care options.

Alternative Facilities

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
Surgery	Ambulatory Surgery Center (ASC)	- Specializes in same-day surgeries - Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more - Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy	Free-standing physical therapy center	Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study	Home testing	- Diagnoses sleep apnea and other conditions - Cost is often covered by insurance if considered medically necessary	Approx. \$4,500*
Infusion therapy	Home or outpatient infusion therapy	- For drugs that must be delivered by intravenous injections, or epidurals - Delivered by licensed infusion therapy provider - Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay*

*In-Network

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as [healthcarebluebook.com](https://www.healthcarebluebook.com) and [healthgrades.com](https://www.healthgrades.com) help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

Preventive Care Screening Benefits

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

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

What is Preventive Care?

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

Visit healthcare.gov/coverage/preventive-care-benefits/ for recommended guidelines.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent. Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

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

Typical screenings for adults

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

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

Turning 65? Understand Your Medicare Options

Alliant Medicare Solutions is a no-cost service available to you, your family members, and friends nearing age 65.



Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

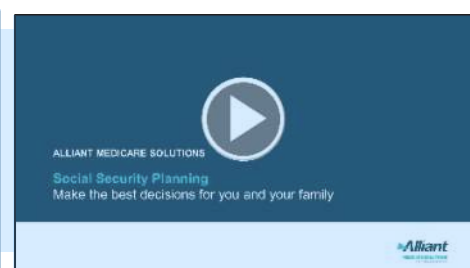
1. Call Alliant Medicare Solutions at **(877) 888-0165** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.



[Your Guide to Medicare](#)



[Medicare 101 Video](#)



[Social Security Planning Video](#)

[**alliantmedicareolutions.com**](http://alliantmedicareolutions.com)

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Employee Assistance Program (EAP)

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through EmployeeConnect with Lincoln Financial Group can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 5 visits per issue
- Unlimited web access to helpful articles, resources, and self-assessment tools

Available Resources

Counseling Benefits

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

Parenting & Childcare

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

Financial Coaching

- Money management
- Debt management
- Identity theft resolution
- Tax issues

Legal Consultation

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Eldercare Resources

- Help with finding appropriate resources to care for an elderly or disabled relative

Online Resources

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

Contact

EmployeeConnect

Phone

888-628-4824

Website

guidanceresources.com

Username: LFGsupport

Password: LFGsupport1





Dental

We offer dental coverage through Delta Dental and United Concordia. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental Plan Overview

This guide serves as a summary of the dental plans. Please review the plan documents before enrolling in coverage.

What you need to know

Delta Dental (ACSIG) PPO

Delta Dental Network

- Out-of-network coverage; higher costs

United Concordia Dental HMO

*United Concordia
Network*

- In-network only
- Requires primary care dentist
- No deductible
- Predictable costs

Dental insurance covers multiple types of treatment:

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

Dental – Delta Dental (ACSIG) PPO

This table shows member cost share.

Delta Dental (ACSIG) PPO*		
	In-Network	Out-of-Network
Annual Deductible	None	
Calendar Year Plan Maximum	\$3,000 per person	\$2,500 per person
Diagnostic & Preventive Exams, Cleanings, X-rays	70%-100%	70%-100%
Basic Services Fillings, Root Canals, Periodontics	70%-100%	70%-100%
Major Services Crowns, Bridges, Implants ¹ Prosthodontics	70%-100% 50%	70%-100% 50%
Dental Accident Benefits Maximum	100% Separate \$1,000 per person per year	100% Separate \$1,000 per person per year
Orthodontia Adults and Dependent Children	50% up to \$2,000 lifetime maximum	

*Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

¹ implant services are covered under annual max

Visit Benefit Bridge or access the [Delta Dental website](#) or app for more details!



What you need to know about this plan

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

Do I have to select a primary dentist?

No. You can see any provider, but you'll pay more out-of-network.

Dental – United Concordia DHMO

This table shows member cost share.

United Concordia Dental HMO*

In-Network

Annual Deductible

None

Calendar Year Plan Maximum

None

Diagnostic & Preventive

Exams, Cleanings, X-rays

\$0-\$15 copay

Basic Services

Fillings

\$0-\$140 copay

Root Canals

\$0-\$45 copay

Periodontics

\$0-\$120 copay

Major Services

\$0-\$245 copay

Orthodontia

Adults

\$2,000 copay; Lifetime maximum: None

Dependent Children

\$1,500 copay; Lifetime maximum: None

*The copays listed on this page are illustrative. Please refer to United Concordia's Dental HMO benefit Summary for the applicable copay for the specific procedure you are interested in having.



What you need to know about this plan

Do I have to select a primary dentist?

Yes

Where can I get more details?

Visit Benefit Bridge or access the [United Concordia website](#) or app or call United Concordia at (866) 357-3304.



Vision

We offer vision coverage through VSP. Vision coverage helps with the cost of eyeglasses or contacts.

Vision Plan Overview

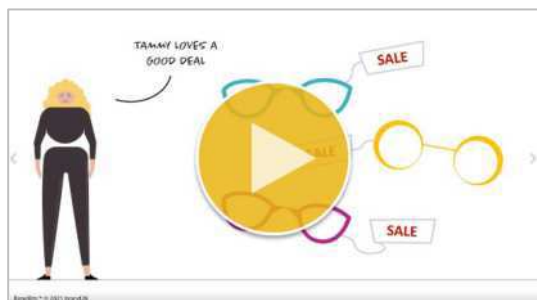
This guide serves as a summary of the vision plan. Please review the plan documents before enrolling in coverage.

What you need to know

VSP Signature Vision (ACSIG)

VSP Signature Network

- Out-of-network coverage will have higher costs
- The plan will reimburse up to a specific dollar amount for most materials



Click to play video

All About Vision

Watch this video to learn more about what to keep an eye out for when it comes to vision insurance.

This table shows member cost share.

VSP Signature Vision		
	In-Network	Out-of-Network Reimbursement
Network Name	VSP Signature	N/A
Exams <i>Once every 12 months</i>	\$5 copay	Up to \$50
Eyeglass Lenses		
Single Vision Lens	\$5 copay	Up to \$50
Bifocal Lens	\$5 copay	Up to \$75
Trifocal Lens	\$5 copay	Up to \$100
Polycarbonate Lens	Covered	Not covered
<i>Once every 12 months</i>		
Frames <i>Once every 12 months</i>	\$200 allowance + 20% off balance \$110 allowance at Costco	Up to \$70
Contacts¹ <i>Once every 12 months</i>	\$200 allowance Save 15% on contact lens exam (fitting and evaluation)	Up to \$105 allowance (combined w/ in-network)

¹In lieu of frames

VSP Perks



What you need to know about this plan

What other services are covered?

The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids. Visit the [VSP.com/offers](https://www.vsp.com/offers) page for more information!

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?

Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

Where can I get more details?

Visit [Benefit Bridge](#) to view the plan summary or access the [VSP website](#) or app. You can also call VSP at 800-877-7195.



Life & Disability

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income.

Is your family protected?

Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

Who is covered

Life and AD&D

Employer Paid

- Employee only

Life and AD&D

Voluntary

- Employee
- Spouse
- Child

Long Term Disability (LTD)

Employer Paid

- Employee only

Short Term Disability (STD)

Employer Paid

- Employee only

Your Beneficiary = Who Gets Paid

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Life and AD&D Insurance

Company Provided Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Lincoln Financial Group and premiums are paid in full by SCCCD.

These benefits are available to all full-time employees with at least 50% assignment.

Employee Life and AD&D Coverage

Employee \$50,000*

***Note:** Benefit amount reduces at age 65. Refer to the plan document for details.

Evidence of Insurability (EOI)

If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (enrolling more than 31 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Lincoln Financial Group. You can find the form at lfg.com.

All About Life Insurance

Watch this video to learn more about what to keep an eye out for when it comes to life insurance.



Additional Features

- **Waiver of Premium** - If you become totally disabled while insured under this plan and under age 60, and complete a waiting period of 180 days, your Basic and Additional Life insurance may continue without premium payment provided you give Lincoln Financial Group satisfactory proof that you remain totally disabled. Please see your certificate of coverage for more details.
- **Accelerated Death Benefit** - If you become terminally ill, you may be eligible to receive increments of \$1,000 of your combined Basic and Additional Life benefit to a maximum of \$500,000 or 80%.
- **Portability** - If your Voluntary Life and AD&D insurance ends because your employment terminates, you may continue to your life insurance coverage by obtaining the cost directly from Lincoln Financial Group.
- **Conversion** - If your Basic and/or Voluntary insurance ends or reduces, you may be eligible to convert your life insurance to an individual life insurance policy without submitting proof of good health. Premiums for the converted policy will be substantially higher compared to the SCCCD sponsored term plan.

Voluntary Life and AD&D Insurance

Protecting those you leave behind

Voluntary Life and AD&D Insurance allows you to purchase additional coverage to protect your family's financial security.

Coverage is provided by Lincoln Financial Group and available for your spouse and/or child(ren).

Life and AD&D Coverage

Employee Increments of \$5,000 up to \$500,000 (or 5x your annual earnings)*
Guaranteed Issue: Lessor of \$300,000 or 3x salary

Spouse Increments of \$5,000 up to \$250,000 (not to exceed 50% of employee amount)*
Guaranteed Issue: \$50,000

Child(ren) Option of \$3,000 or \$5,000 (age 1 day to 6 moths: \$250)
Guaranteed Issue: \$5,000

AD&D Coverage

Employee Increments of \$5,000 up to \$500,000 (or 5x your annual earnings)*

Spouse 50% of employee amount if you DO NOT have children enrolled in Voluntary AD&D*
60% of employee amount if you DO have children enrolled in Voluntary AD&D*

Child(ren) 25% of employee amount if you DO NOT have a spouse enrolled in Voluntary AD&D
10% of employee amount if you DO have a spouse enrolled in Voluntary AD&D

*Benefit amount reduces at age 65.

Evidence of Insurability (EOI)

If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (enrolling more than 31 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Lincoln Financial Group. You can find the form at lfg.com.



Voluntary Life & AD&D Insurance Costs

If you elect voluntary coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck.

Voluntary Life Insurance

Tenthly Rate Per \$1,000 of Coverage

Age	Employee	Spouse
<29	\$0.070	\$0.070
30-34	\$0.080	\$0.080
35-39	\$0.090	\$0.090
40-44	\$0.160	\$0.160
45-49	\$0.250	\$0.250
50-54	\$0.410	\$0.410
55-59	\$0.730	\$0.730
60-64	\$1.090	\$1.090
65-69	\$1.670	\$1.670
70-74	\$3.320	\$3.320
75+	\$5.670	\$5.670

Voluntary AD&D – Tenthly Rate Per \$1,000 of Coverage

Employee & Spouse	\$0.032
Child(ren)	\$0.049

To calculate your per paycheck AD&D cost, follow the same steps as the table above.

Calculate Your Life Insurance Cost

1. Desired Coverage (\$1,000 Increments)

You: Spouse:

2. Divide Step 1 by 1,000 =

You: Spouse:

3. Multiply Step 2 by Rate from Table =

You: Spouse:

4. Add You + Spouse from Step 4:

TOTAL COST PER PAYCHECK:

Child Life Insurance

Coverage Amount	Tenthly Rate per \$1,000 of coverage
\$3,000	\$0.15
\$5,000	\$0.25

Premium includes all eligible children.

Eligible children include dependent children under age 26 as long as you apply for and are approved for coverage for yourself.

Disability Insurance

Short-Term Disability Insurance (STD)

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. SCCCD pays the cost of this coverage. Coverage is provided by Lincoln Financial Group.

Eligibility	All Full-Time Faculty employees with at least 50% assignment with 5 or more years of service
Weekly Benefit Amount	66.67% up to a maximum of \$1,400
Benefits Begin After	
Accident	120 days
Sickness	120 days
Maximum Payment Period¹	52 weeks

¹Maximum payment period is based on the first day benefits begin, not the first day you are disabled.

Submitting a Claim

If you are disabled due to an illness or accidental injury, unable to work, and under the care of a licensed physician, you are eligible to submit a claim for benefits under this plan. As long as you remain disabled and meet the plan's disability requirements, you will continue to receive a percentage of your earnings until benefits are no longer payable.

Long-Term Disability Insurance (LTD)

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. SCCCD pays the cost of this coverage. Coverage is provided by Lincoln Financial Group.

Eligibility	All Full-Time Faculty employees with less than 5 years of service
Monthly Benefit Amount	66.67% up to a maximum of \$6,000
Benefits Begin After	
Accident	120 days
Sickness	120 days
Maximum Payment Period¹	Social Security Normal Retirement Age

¹The age in which you are disabled may affect the length of the maximum benefit period.

What to Know About LTD Insurance

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.



Voluntary Plans

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs. You pay the entire cost for these plans.

For more information regarding costs of coverage benefit offerings please visit the [American Fidelity website](#).

Accident Insurance

Limited Benefit Accident Only Insurance from American Fidelity helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

Cancer Insurance

Many people are concerned about the financial impact of a cancer diagnosis. Limited Benefit Cancer insurance provides tax-free benefits for many of the costs associated with cancer treatment such as radiation, chemo, surgery, diagnostic tests, and physician charges. You can cover yourself and your family members if needed. American Fidelity provides coverage for this program.

Critical Illness Insurance

Limited Benefit Critical illness insurance from American Fidelity can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

Additional Voluntary Benefits

American Fidelity offers these additional voluntary benefits to assist you in your time of need:

- Disability Income Insurance
- Whole Life Insurance
- Term Life Insurance
- Universal Life Insurance

Speak to an American Fidelity representative to inquire about your coverage options.

Plans to Keep You and Your Family Secure

Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. MetLife provides coverage for this program. You can enroll in this program at any time.

Visit the Plan
Contacts section for
contact information.





Financial Wellness

We offer benefits and resources to help you make the most of your money now and in the future.

Why Does Financial Wellness Matter?

Financial wellness directly impacts various aspects of your life, including physical and mental health, relationships, and career satisfaction. A strong financial footing reduces stress and anxiety related to money, leading to better mental health and overall quality of life. It enables you to pursue your goals, whether it's buying a home, starting a family, or planning for retirement, without the constant burden of financial worry.

What you need to know

Healthcare Flexible Spending Account (FSA)

Use tax-free dollars for healthcare related expenses.

Dependent Care Flexible Spending Account (FSA)

Use tax-free dollars for childcare expenses.

Flexible Spending Account (FSA)

IMPORTANT: You must re-enroll in this account each year. Elections do not rollover.

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses. This program is administered through American Fidelity.

How the FSA Works

You estimate what you and your family's eligible out-of-pocket costs will be for the coming year, expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.

- Use the FSA debit card to pay for eligible services and products. You can also login to your online account or use your mobile app to request a payment be sent directly to your provider or to you.
- Request an itemized receipt for any expenses you plan to pay for with your FSA.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.

2025 IRS Contribution Limits

You can contribute up to \$3,300.

Contributions are deducted from your pay pre-tax.

Deadline To Incur Claims

Expenses must be incurred between 10/01/2025 and 09/30/2026.

Deadline To Submit Claims

Claims must be submitted for reimbursement no later than 90 days after the end of the plan year.

Rollover

You can rollover up to \$660 to use the following year. Any additional remaining balance will be forfeited.

Are You Eligible?

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

Do You Pay For Dependent Care?

Review the next page for information on tax savings through the Dependent Care FSA.

Find out more

- [American Fidelity site](#)
- [Eligible Expenses](#)
- [Ineligible Expenses](#)

A SPECIAL ENROLLMENT IS HELD FOR AMERICAN FIDELITY BENEFITS ONLY.

Additional Tax-Saving Accounts

You must re-enroll in this account each year. Elections do not rollover.

Dependent Care Flexible Spending Account (FSA)

Paying For Daycare? Make It Tax-free! A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by American Fidelity.

How the Dependent Care Flexible Spending Account (FSA) Works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

2025-2026 IRS Contribution limits

You can contribute up to \$5,000 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to \$2,500 each year

Deadline to incur expenses

Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year.

Rollover

Unspent funds will be forfeited.

You can't change your Dependent Care FSA election amount mid-year unless you experience a qualifying event.

A SPECIAL ENROLLMENT IS HELD FOR AMERICAN FIDELITY BENEFITS ONLY.

You can't change your Dependent Care FSA election amount mid-year unless you experience a qualifying event.





Important Plan Information

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

	What you need to know
Important Contacts	Contact information for our benefit carriers and vendors.
Benefits Glossary	A Benefits Glossary to help you understand important insurance terms.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify CLIENT NAME if your domestic partner is your tax dependent.

Plan Contacts

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website/Email
Dental PPO	Delta Dental	(866) 499-3001	deltadentalins.com
Dental HMO	United Concordia	(866) 357-3304	unitedconcordia.com
Vision	VSP	(800) 877-7195	vsp.com
Life and AD&D Voluntary Life and AD&D Long-Term Disability, Short-Term Disability	Lincoln Financial Group	(800) 423-2765 Group ID: SANTACLARI	lfg.com
Employee Assistance Program (All Employees)	ComPsych	(888) 628-4824	guidanceresources.com Username: LFGsupport Password: LFGsupport1
Human Resources Phone: (661) 362-3427			

Glossary

-A-

AD&D Insurance

An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount

The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)

A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit

A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing

In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is \$100 but the plan's allowable charge is only \$70, an out-of-network provider may bill YOU for the \$30 difference (the balance).

Beneficiary

The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug

A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA

A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim

A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance

Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment

A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible

The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services. Family coverage may have an **aggregate** or **embedded** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services

Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive

Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services

Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)

An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for

children underage

13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense

A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service

A service that your health plan doesn't pay for or cover.

-F-

Formulary

A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug

A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered

A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA)

An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)

A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A

medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

Glossary

-I-

In-Network

In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance

An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance

Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order

A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment

The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network

Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of-network services at all.

Out-of-Pocket Cost

A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum

Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care

Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy

A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year

A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug

Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services

Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)

The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance

Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine

A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care

Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations

Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit

An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

Notes

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