



SCC of SDA 2026



Employee Benefits Guide
January 1, 2026 - December 31, 2026



January 2026

Dear Employees,

Southern California Conference of Seventh-day Adventists (SCCSDA) remains committed to hiring and retaining the best, most talented people for our Conference. We foster a supportive environment where your contributions can be appreciated and recognized. We value your hard work and commitment and want you to grow and accomplish incredible things, as we pursue our mission to exalt Christ by cultivating healthy churches and schools.

We have developed this guide to help you understand your employee benefits. We offer you the opportunity to stay healthy and secure with a comprehensive benefits program and help you achieve financial goals through tax savings and retirement plans.

As the healthcare landscape in our country continues to evolve due to healthcare reforms, we annually evaluate and, when necessary, make modifications to our benefits programs in order to offer you and your dependents the best overall healthcare package. SCCSDA continues to contribute a significant portion of the group benefits plan cost for each qualifying employee. It is our desire to provide the maximum level of benefits while keeping your cost and our organization's cost as low as possible.

On behalf of our administration, I appreciate your support of SCCSDA in fulfilling its mission to exalt Christ by serving others. Thank you for your service to this Conference.

Sincerely,

John Cress

President

Southern California Conference of Seventh-day Adventists

2026 EMPLOYEE BENEFITS GUIDE



Welcome to Your Benefits Guide

At Southern California Conference of Seventh-day Adventists we are committed to providing our employees with a comprehensive, high quality, affordable employee benefits program that meets your needs and serves as an integral and valuable component of the total compensation package.

Please take a moment to read through this brochure and familiarize yourself with the benefits available to you as an employee of Southern California Conference of Seventh-day Adventists

This brochure is intended to be a summary of the benefit plans we offer, which are subject to change at any time.

Who is Eligible for Employee Benefits?

Eligible employees and their dependents may participate in the benefits program. Benefits are effective first of the month following employment or a change in employment status. Eligible dependents may include spouse, children under 26, children who are age 26 or older and mentally or physically disabled, and children including biological children, step-children, children covered under a child support order, or adopted children.

Paying for Coverage

SCCSDA pays a significant portion of the premium cost of many of your benefits to cover you and your eligible dependents. The portion that you pay for medical, dental, vision, and the flexible spending accounts is deducted from your paycheck on a pre-tax basis. This means that the income you use to pay for these benefits is not taxed, putting dollars back into your pocket. SCCSDA pays 100% of the premium for the Basic Life and Long-Term Disability coverage for employees who are eligible for these programs.

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Making Changes to Your Benefits

The benefits plan year runs from January 1 to December 31 each year. You may make changes to your benefit choices during the annual Open Enrollment period or when you have a qualifying event. Notify Human Resources **within 30** days of the qualifying event. Qualifying Events are change in legal marital status, childbirth or adoption, loss of healthcare coverage, divorce or legal separation resulting in a loss of coverage, or a dependent's eligibility ceases resulting in a loss of coverage.

Medical Plan

Southern California Conference of Seventh-day Adventists offers the following health insurance:

- Custom Full PPO Savings (HSA)

You Must Enroll in Medical Coverage

If you are eligible, you must enroll in medical coverage during your new hire eligibility period.

If you choose to decline coverage because you have other coverage available, you must provide Human Resources with evidence that you have other qualifying coverage. You may have the option to enroll during the year if you experience a qualifying event. Please be sure you consult with Human Resources within the 30-days of any qualifying event.



How to Enroll

1. Review the plan information contained throughout this Benefit Information Guide.
2. Review medical, dental and vision providers by accessing the provider websites. The web address and contact information can be found in the Guide on page 14.
3. Complete your enrollment on Workterra, our online enrollment system. Workterra allows you to:
 - Enroll in your benefit plans
 - Verify your benefit enrollment selections throughout the year
 - Update addresses and personal info
 - Access forms, plan documents and links to websites

To enroll, follow these steps:

1. Launch an Internet browser such as Internet Explorer
2. Navigate to <https://workterra.net>
3. Enter the information below and click **Login**
 - **User Name:** First letter of your first name, first six letters of your last name & last four numbers of your SSN.
 - **Password:** First 5 of your SSN
(Example: if your SSN is 555-02-xxx, use "55502")
 - **Company:** SCC of SDA
4. **Welcome Page** - Please read your Welcome Page Information and the click the box next to the *Employee Usage Agreement and Legal Agreement*. Once you have read both, select **Continue**.
5. **Demographics & Dependents** - Review, add, or update your demographic, your spouse or child information.
6. **Plan Elections** - Follow the steps to enroll in your benefits. If you are not interested in a particular benefit, you may **waive** that benefit. Be sure you select each person you want to cover for each benefit.
7. **Navigation** - Please be sure to use only the navigational buttons provided within the tool. **Back Do not use your browser's back button.**
8. **Beneficiaries** - Add your beneficiaries.
9. **Completing the Enrollment Process** - After completing all your plan elections, you will come to the Confirmation Statement. Review all your elections. Print a copy. Hit the **Finish** button.

MEDICAL

The Blue Shield PPO HSA medical plan has a wide provider network. When choosing this plan, be sure to review the providers available in the network. You can search online at anthem.com. See page 16 of this guide for step-by-step directions to look up providers.

Custom PPO Savings HDHP/HSA		
General Plan Provisions	In-Network *	Out-of-Network **
Calendar Year Deductible	\$5,500 Individual \$11,000 Family	\$12,000 Individual \$24,000 Family
Calendar Year Out-of-pocket Maximum	\$6,650 Individual \$13,300 Family	\$15,000 Individual \$30,000 Family
Preventative Care	Covered at 100%	Not Covered
X-ray & Laboratory Services	0% coinsurance	50% coinsurance
Complex Imaging / Labs	0% coinsurance	50% coinsurance
Physician Office Visit	0% coinsurance	50% coinsurance
Specialist Office Visit	0% coinsurance	50% coinsurance
Inpatient Hospitalization	0% coinsurance	50% coinsurance max benefit \$600 / day
Outpatient Surgery	0% coinsurance	50% coinsurance max benefit \$350 / day
Urgent Care	0% coinsurance	50% coinsurance
Emergency Room Services	0% coinsurance	0% coinsurance
Ground Ambulance	0% coinsurance	0% coinsurance
Retail Prescriptions (30-day supply)	After Deductible Tier 1: \$5 / prescription Tier 2: \$50 / prescription Tier 3: \$75 / prescription Tier 4: 30% \$250 Max after deductible	In-Network Copay + 25%
Mail Order (90-day supply)	After Deductible Tier 1: \$10 / prescription Tier 2: \$100 / prescription Tier 3: 150 / prescription Tier 4: 30% up to \$500 / prescription	Not Covered

* Calendar Year Deductible applies to all medical services and Rx with the exception of Preventive Services which is covered at a 100%. However, if you receive both Preventive Services and other covered Services during office visit, you may have a Copay or Coinsurance for the visit.

** When using Out of Network providers Blue Shield limits coverage. Please make sure you understand that by going to an Out of Network provider, you will be subject to substantially more out of pocket costs.

This is a brief summary of the benefits available from Southern California Conference of Seventh-day Adventists In the event of a discrepancy between this summary and the plan document, the plan document will prevail. Southern California Conference of Seventh-day Adventists retains the right to modify or eliminate any benefits, at any time, and for any reason.

MEDICAL EMPLOYEE CONTRIBUTIONS

MEDICAL / DENTAL / VISION	
	Employee Monthly Cost
Employee Only	\$92.12
Employee + Spouse	\$184.24
Employee + Childr(ren)	\$184.24
Employee + Family	\$276.36
EMPLOYEE PREMIUM INCLUDES MEDICAL+ DENTAL + VISION	

Working Spouse's eligibility is contingent on verification of lack of employer's offer of healthcare and proof of salary within NAD's guidelines.

Meeting your Deductible and Out of Pocket Maximum (OOPM)

	<u>Deductible & Out of Pocket Maximum</u>	
	Single	Family (2 or more)
Deductible	\$5,500.00	\$11,000.00
Employee pays first	\$ 300.00	\$ 600.00
Remaining Deductible	\$5,200.00	\$10,400.00
Employer will reimburse up to	<u>\$3,575.00</u>	<u>\$ 7,150.00</u>
Employee pays remaining deductible	\$1,625.00	\$ 3,250.00
Out of Pocket Maximum	\$6,650.00	\$13,300.00
Deductible	<u>\$5,500.00</u>	<u>\$11,000.00</u>
Remaining Out of Pocket Maximum	\$ 1,150.00	\$ 2,300.00
Employee pays first OOPM	\$ 390.00	\$ 780.00
Employer pays remaining OOPM	\$ 760.00	\$ 1,520.00
Maximum Employee Liability	<u>\$ 2,315.00</u>	<u>\$ 4,630.00</u>

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HEALTH SAVINGS ACCOUNT (HSA)

Health Savings Accounts (HSA) allow individuals with a High Deductible Health Plan (HDHP) to put pre-tax (federally) funds into an interest-bearing bank account to help pay for medical expenses.

The introduction of HSAs is truly changing the way we pay for healthcare. Unlike traditional health insurance coverage, as an HSA account holder, you are in control of how you save and spend for medical expenses.

A Health Savings Account in conjunction with the Blue Shield PPO HDHP / HSA plan is a way for you to pay for your health and medical expenses while saving money for health expenses during retirement. Simply put, an HSA is a tax-advantaged cash and investment account that can be used to pay for qualified medical expenses. Unused funds rollover each year and grow tax free helping you save for future medical expenditures.

When you enroll in the Blue Shield PPO HDHP/HSA plan, you will be automatically enrolled in an Optum Bank HSA if you choose to make contributions.

How to access your Optum Bank HSA

1. Go to www.optumbank.com and sign in. If you are a new user, click "Create your Profile".
2. Start using the online tools available to help you manage your account.

You will receive your Optum Card in the mail, in a plain white envelope. If you already have an Optum card, continue to use the card until it expires.

- If you receive a card, do not forget to activate it
- Take note of the personal identification number (PIN) assigned to your card

Who is eligible to contribute to an HSA?

Anyone who is:

- Enrolled in a HDHP/HSA Plan
- Not covered under another medical plan that is not a HDHP
- Not receiving Medicare benefits
- Not receiving Social Security benefits
- Not eligible to be claimed on another person's tax return

When do I use my HSA?

After visiting a physician, facility, or pharmacy, you may submit the charges to your HSA for payment. Your HSA dollars can be used to pay your out-of-pocket expenses (deductible and coinsurance) billed by the physician facility, or pharmacy or you can choose to save your HSA dollars for a future medical expense.

How much can I contribute to an HSA?

2025	2026
Single: \$4,300 Family: \$8,550	Single: \$4,400 Family: \$8,750

Individuals age 55 or older can make an additional catch-up contribution of \$1,000.



Contact Optum Bank:

Our customer support center is available for assistance **24/7, at 866-234-8913**

DENTAL

The PPO dental plan is designed to allow you the choice of receiving your dental care from from any licensed dentist you wish. You receive the maximum benefits available under the plan when you choose a contracted dentist with DPPO Provider Network. In addition, no claim forms are required. When you go out-of-network, you will not receive any provider discounts and your out-of-pocket expenses will be greater.

Blue Shield DPPO		
Services	In-Network	Out-of-Network
Calendar Year Deductible	\$50 Single / \$150 Family	\$50 Single / \$150 Family
Annual Benefit Maximum	\$2,500	\$2,500
Preventative Care	Covered 100%	Covered 100% * MAC
Basic	90% Negotiated Rate	80% * MAC
Major	60% Negotiated Rate	50% * MAC
Endodontics	90% Negotiated Rate	80% *MAC
Periodontics	90% Negotiated Rate	80% *MAC
Orthodontics (Child Only)	50% (Max \$1,500)	50% (Max \$1,500)

MAC = Maximum allowed charge. Any time you receive services from an out of network provider the dentist will balance bill you.



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VISION

When you use a Blue Shield vision provider, you are responsible for a co-payment at the time of service. Your provider will file a claim for you and be reimbursed directly from Blue Shield. If you see an out-of-network provider, you pay all expenses at the time of service and submit a claim reimbursement up to the allowance shown in the vision highlights chart below.

Blue Shield Vision		
General Plan Provisions	In-Network	Out-of-Network
Exams: Once every 12 months	\$10 copay	All charges above \$60
Lenses; Single, Bifocal & Trifocal Once every 12 months	\$0 copay	Up to \$43, \$60, \$75
Frames: Once every 12 months	\$150 Allowance	All charges about \$120
Contacts: Once every 12 months Elective Medically Necessary	\$150 Allowance Covered in Full	Reimburse up to \$120 Reimburse up to \$250

LIFE / ACCIDENTAL DEATH & DISMEMBERMENT

Voya Life/AD&D	
Schedule of Benefits	
Definition of Class	All Full-time Eligible Employees
Basic Life	\$100,000 Employee, \$50,000 Spouse
AD&D	\$100,000 Employee Only



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VOLUNTARY LIFE/AD&D

Reliance Matrix Voluntary Life/AD&D

Employee

All employees may purchase additional Life Insurance in increments of \$10,000 to a maximum of \$500,000 but not to exceed 7x your basic annual earnings. **Guarantee Issue Amount of \$150,000 (under the age of 70)**. The cost of this coverage depends on the desired amount of coverage at your age of purchase.

Employees Must Elect Optional Life / AD&D Coverage to Elect Dependent Coverage

Spouse

All spouses may purchase additional Life Insurance, assuming employee coverage was purchased as well, in increments of \$5,000 to a maximum of \$250,000 but not to exceed 50% of employee election. The cost of this coverage depends on the desired amount of coverage at "Employee" age of purchase. **Guarantee Issue Amount of \$50,000 (under the age of 70)**.

Child(ren)

All child(ren) may purchase additional Life Insurance, assuming employee coverage was purchased as well, up to of \$25,000. Child(ren) can be covered until age 26. **Guarantee Issue Amount of \$25,000 for children (6 months to 26 years old. Live birth to 6 months Guarantee Issue Amount of \$1,000)**.

LONG TERM DISABILITY

Employer Paid Long Term Disability Insurance (LTD)

We also offer Employer Paid Long Term Disability Insurance. This benefit will vary based on your income.

Reliance Standard Long Term Disability	
Schedule of Benefits	
Benefit	66.67% of pre-tax monthly earnings
Maximum Amount	\$6,000 / month
Minimum Amount	\$100 / month
Duration	SSNRA + 5 years with loss of 2 ADL's
Elimination Period	90 days

EAP

Confidential Counseling on Personal Issues

Your Employee Assistance Program (EAP) is a confidential assistance program to help address the personal issues you and your dependents are facing. This service, staffed by experienced clinicians, is available by phone 24 hours a day, seven days a week. A Guidance Consultant is available to listen to your concerns and refer you to a local provider for an in-person counseling or to resources in your community. Call any time with personal concerns, including:

- Depression
- Marital and family conflicts
- Job pressures
- Stress and anxiety
- Alcohol and drug abuse
- Grief and loss

Legal Information, Resources and Consultation

When a legal issue arises, our attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call any time with legal issues including:

- Divorce and family law
- Debt obligations
- Landlord and tenant issues
- Real estate transactions
- Bankruptcy
- Criminal actions
- Civil lawsuits
- Contracts

Online Information, Tools and Services

Reliance Matrix your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns. Create your own account by going to <http://allonehealth.com/reliance-matrix>. Each time you return to the site, you will find personalized, relevant information based on your individual life needs. You can:

- Mental Health Sessions, Life Coaching
- Financial Consultation, Legal Consultation
- Life Management, Personal Assistant
- Medical Advocacy, Member Portal and App

Financial Information, Resources and Tools

Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

- Saving for college
- Getting out of debt
- Retirement planning
- Tax questions
- Estate planning

Common Issues Include

- ▶ Marital/relationship problems
- ▶ Parenting issues
- ▶ Depression/anxiety
- ▶ Bereavement or grief counseling
- ▶ Substance abuse & recovery

Available 24 hours a day, 7 days a week

Call: 855-775-4357

Online: <http://allonehealth.com/reliance-matrix>

Company Code: RSLI859

SCC SPECIALTY PLANS

Employee must be enrolled in Blue Shield to be eligible for specialty plans.

Alternative Health Care

SCCSDA recognizes the potential value and benefits of alternative health care and lifestyle enhancement programs. Fairness and exercise of good stewardship require that appropriate expectations be in place and that the health care measurable benefits. Maximum assistance level is \$2,500 or 50% of the treatment costs for the patient, whichever is less. There is no reimbursement for travel expenses, lost wages or companion's expenses. Pre-authorization is required.

Marriage & Family Counseling Reimbursement Assistance

Financial assistance from the Conference may be available by completing the online application form at [Mental Health/Counseling Plan](#) and submit supporting documentation from Blue Shield along with proof of payment and explanation of benefits (EOB). The assistance amount is a reimbursement of 80% of employee's eligible received expenses.

Dental Implant Assistance Plan

The Conference provides dental implant assistance to employees and eligible family members who are covered by the Blue Shield dental plan. The assistance amount is a reimbursement at 60% of employee's PPO coinsurance payment. For out-of-network dentists, the assistance amount will be at 50%. Pre-authorization is required. Proof of payment and the explanation of benefits (EOB) statement from Blue Shield website are required for any reimbursement. Complete and submit the online application form to your HR office.

Filing a Claim

Pre-approval for reimbursement MUST be obtained from HR BEFORE STARTING TREATMENT!

Participants can download a claim form from SCC website. Participants must submit an Explanation of Benefits (EOB) from Blue Shield or visit statements with proof of payment with the claim form to secure reimbursement from this account.



RETIREMENT PLAN

403(b) Plan Information

One of the most important decisions you make while working is finding a convenient way to save for your retirement. SCCSDA's 403(b) plan offers tax savings, matching contributions, and a selection from a variety of investments to help you reach your retirement goals.

The employer makes a 5% basic contribution to your retirement account and a dollar-for-dollar matching contribution up to the first 3% of your eligible compensation on amounts that you contribute. For more information on the plan, please visit www.adventistretirement.org.

As a new hire, you are automatically enrolled in the Adventist Retirement Plan maintained by Empower Retirement. 3% will be taken from your eligible compensation as a salary reduction contribution to the plan. Plan participants who are not making salary reduction contributions of at least 15%, will automatically have their salary reduction contribution increased by 1% every July 1 until your contribution percentage reaches 15%. If you do not wish to participate in the automatic initial enrollment and/or automatic escalation feature, you must log on to <https://participant.empower-retirement.com> or call (866) 467-7756 to opt out of these plan features.

*** The maximum contribution for 2026 is \$24,500. Individuals 50+ can contribute an additional \$8,000.**



LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNTS

Your Limited Purpose FSA

Anyone currently enrolled in an H.S.A. account can also participate in Limited Purpose FSA. We would encourage all participants to max out your H.S.A. account first if eligible to contribute to an H.S.A.. Otherwise money put into a limited purpose FSA can only be spent on dental and vision, not medical expenses. Remember Limited Purpose FSA is use it or lose it!

You may choose to participate in the following account Health Care limited FSA:

- \$3,300 maximum Limited Purpose for dental & vision expenses

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (January 1st to December 31st) Health Care Reimbursement, Dependent Care Reimbursement, & Commuter Reimbursement

Give yourself a raise by increasing your take home pay!

- Pre-tax Deductions
- Healthcare Reimbursement
- Dependent Care Reimbursement

Who would want to participate in the plan?

Anyone who has regular, planned, or predictable out-of-pocket covered expenditures should consider opening an FSA.

What is covered?

- Eligible health care costs that are not covered by insurance such as medical deductibles, co-pays, and over-the-counter items. (Note: Many over-the-counter items require a prescription from a physician.)
- Dependent Care costs for the hours you are at work.

Health Care Reimbursement or Limited Purpose Health Care Reimbursement (Dental and Vision Only)

Health Care Reimbursement enables you to pay, on pre-tax basis, for medical, dental, and vision expenses not covered by your insurance program (**up to \$3,400 annual maximum**). See Human Resources for information on how to receive a debit card or you can file a claim for personal payments made.

- Coverage is for you, your spouse, and any eligible dependents.
- Healthcare is reimbursed based on your annual election amount.

Below is a list of some of the expenses that are reimbursable through your FSA Health Care Account. You can review eligible expenses list at: www.flores247.com

- | | | |
|---------------------------|---------------------------|-------------------------|
| • Ambulance Service | • Diabetic Supplies | • Pediatrician's Fees |
| • Anesthesiologist's Fees | • Diagnostic, Lab, X-rays | • Podiatrist's Fees |
| • Contact Lenses | • Eye Exams & Glasses | • Prescription Drugs |
| • Co-payments | • Fertility Treatments | • Psychiatrist's Fees |
| • Crutches | • OB/GYN Treatments | • Routine Care |
| • Deductibles | • Office Visits | • Stop Smoking Programs |
| • Dental Services | • Orthodontia | • Chiropractic Visits |

Paycheck WITHOUT the FSA:

Annual Earnings:	\$35,000
FICA, Federal, State tax:	\$8,750
Insurance Premium:	\$1,200
Health Expenses:	<u>\$3,600</u>
Take Home Pay:	\$21,450

Paycheck WITH the FSA:

Annual Earnings:	\$35,000
Insurance Premium:	\$1,200
Health Expenses:	\$3,600
Adjusted Earnings:	\$30,200
FICA, Federal, State tax:	<u>\$7,550</u>
Take Home Pay:	\$22,650
TAX SAVINGS	\$1,200

FLEXIBLE SPENDING ACCOUNTS

Dependent Care Reimbursement

The Dependent Care Reimbursement Account enables you to make payroll deductions to cover childcare (daycare) or elder care expenses **up to \$7,500 for single filers or married couples filing jointly and \$3,750 for those married filing separately** before taxes.

- A dependent must be either under age 13 or any age if disabled.
- This benefit allows you to be reimbursed for childcare expenses incurred while you and your spouse work or attend school (social events not applicable).
- Expenses cannot exceed the lower income of either spouse.
- If using a daycare center it must be licensed.
- A dependent relative under age 19 may not provide baby-sitting services.
- Overnight camps are not eligible unless 'daycare' portion is separately invoiced.

After school programs, summer day camps, and elder care are eligible. By participating in this plan you are reducing your total child care tax credit by the amount that you elect. Please note that private school for school aged children expenses are not eligible. Dependent Care is reimbursed based on your total claims submitted and your account balance.

Key Information about Dependent Care

Dependent care reimbursement must be for expenses incurred during the period of coverage. If you are participating in the program, information on your account balance is available online at www.flores247.com

Enrollment Considerations

Be conservative in your estimates. Once you have elected to participate, your election will not change unless there is a qualifying event.

The following are qualifying events: Change in marital status (marriage, divorce, death of spouse), birth/adoption of a child, or change in your or your spouse's employment status. The type of Qualifying Event determines the type of change you are allowed to make. Consult Human Resources with questions.

Use it or Lose it Rule and Termination

After the **Run-Out Period (March 31, 2026)** all remaining funds in the healthcare or dependent care accounts will be forfeited. All claims must be received by Flores or postmarked by the last day of the Run-Out Period. The Grace Period for expenses is 2 months and the deadline to submit claims is 30 days after. In the case of termination of employment, your termination date will be defined as your last day of employment. Only expenses incurred through your termination date will be eligible and they must be submitted for reimbursement no later than the 90th day after your termination date.

Submission Options:

1. Employee Portal
www.flores247.com
2. Call: 888.586.3994
3. Fax: 800.726.9982
4. Mail: PO Box 31397 Charlotte, NC 28231

**DON'T FORGET ABOUT THE
FLORES BENEFITS MOBILE APPLICATION**



PROVIDER FINDER

Need help finding a Blue Shield Medical Provider:

- ▶ blueshieldca.com
- ▶ Click "Find a doctor"
- ▶ Select "Doctors & Specialists"
- ▶ Continue as a guest
- ▶ Enter your zip code
- ▶ Click "Select a plan"
- ▶ Select a year "2026"
- ▶ Choose a plan type - "**2026 Employer Group Plans (101+ Employees)**"
- ▶ Select a Subplan - "PPO"
- ▶ Click "Continue with this Plan"
- ▶ List of specialties choose - "General Practice"
- ▶ Search

Need help finding an Blue Shield Dental Provider:

- ▶ blueshieldca.com
- ▶ Click "Find a doctor"
- ▶ Select "Dentists"
- ▶ Select "Continue as a guest"
- ▶ Enter your zip code
- ▶ Click "Continue"
- ▶ Select plan year "2026"
- ▶ Select plan type "**Dental PPO (Group plans)**"
- ▶ Click "Continue with this plan"
- ▶ Select "General Dentist / Primary Care Dentist"
- ▶ Click "Search"



Need help finding a Blue Shield Vision Provider:

- ▶ blueshieldca.com
- ▶ Click "Find a doctor"
- ▶ Select "Vision Care"
- ▶ Select "Continue as a guest"
- ▶ Enter your zip code
- ▶ Click "Continue"
- ▶ Select plan year "2026"
- ▶ Select plan type "Vision - all other"
- ▶ Click "Continue with this plan"
- ▶ Select "Optometrist"
- ▶ Click "Search"

2026 ANNUAL NOTICES

The following are important summaries of plan notices consolidated for your ease of reference. These notices describe minimum protections under federal law. States may require insurers and HMO's to provide additional protections to individuals in that state. Please refer to the more comprehensive benefits plan documents from our insurance carriers for further detail. In the event of a conflict between this summary and the carrier's contracts and agreements, the terms of the official plan documents will govern.

Newborns' and Mothers' Health Protection Act

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

Special Enrollment Notice

If an eligible employee declines enrollment in this group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if eligibility is lost for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within 30-days after the other coverage ends (or after the employer ceases contributions for the coverage).

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within 30-days after the marriage, birth, adoption, or placement for adoption. If the eligible employee otherwise declines to enroll, he/she may be required to wait until the group's next open enrollment to do so. The eligible employee also may be subject to additional limitations on the coverage available at that time.

Furthermore, eligible employees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after (a) becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or (b) being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan.

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in SCCSDA group medical plans.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at 888-789-7810.

HIPAA PRIVACY RIGHTS

HIPAA also requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice or, if appropriate, in the privacy notice provided by the insurer. To obtain a copy of the privacy notice, contact the insurer or, if you have questions or complaints about the privacy of your health information, contact the Plan Administrator.

Neither this Plan nor the Employer will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan, your insurer, or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

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The following are important summaries of plan notices consolidated for your ease of reference. These notices describe minimum protections under federal law. States may require insurers and HMO's to provide additional protections to individuals in that state. Please refer to the more comprehensive benefits plan documents from our insurance carriers for further detail. In the event of a conflict between this summary and the carrier's contracts and agreements, the terms of the official plan documents will govern.

USERRA Notice

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you,

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
 - Initial employment;
 - Reemployment;
 - Retention in employment;
 - Promotion; or
 - Any benefit of employment because of this status.

USERRA Notice _Continued

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

·If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

·Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

·The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at <http://www.dol.gov/vets>. An interactive online USERRA Advisor can be viewed at <http://www.dol.gov/elaws/userra.htm>.

·If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

·You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

2026 ANNUAL NOTICES

Medicare Part D - Creditable Coverage Notice

Important Notice from SCCSDA About Your Prescription Drug Coverage and Medicare

This Notice Applies to You (or Dependent) ONLY if such person is (1) enrolled in a group medical plan offered by SCCSDA AND (2) eligible for 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 Blue Shield 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. SCCSDA has determined that the prescription drug coverage offered by the SCCSDA PPO's are on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current SCCSDA coverage will not be affected.

We have stated your current employer sponsored prescription drug plan below.

Medical Carrier	Prescription Drug Co-payment			
	Tier 1	Tier 2	Tier 3	Tier 4
Blue Shield HSA	\$5	\$50	\$75	30% \$250 max after deductible

The CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>) will outline the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you decide to join a Medicare drug plan and drop your current SCCSDA coverage, be aware that you and your dependents will 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 SCCSDA 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 credible coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SCCSDA changes. You also may request a copy of this notice at any time.

For More Information 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:	January 1st 2026
Name of Entity/Sender:	Southern California Conference of Seventh-day Adventists
Contact:	Belinda Simoni
Address:	1535 E. Chevy Chase Dr. Glendale, CA 91206-4107
Phone Number:	(818) 546-8415

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Patient Protection

Blue Shield HMO generally encourages the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, Blue Shield HMO designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Member Service Department at (800) 258-3091.

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

You do not need prior authorization from Blue Shield HMO or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedure for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Blue Shield HMO Member Service Department at (800) 258-3091.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, an/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plans' network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-Network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a services. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency, or when you schedule a visit at an in-network facility, but are unexpectedly treated by an out-of-network provider.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

General Description of Rights and Obligations When Electing COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If, during the course of employment, a "qualifying event" occurs, HR must be notified in writing of the "qualifying event" within 60 days of the event.

Plans subject to COBRA continuation:

- Medical
- Dental
- Vision
- Medical FSA (with a positive cash balance)

"QUALIFYING EVENTS" are:

Termination of the employee's employment (other than for gross misconduct) or reduction of hours worked which renders loss of coverage to the employee and/or covered dependents;

- Death of the employee
- Divorce or legal separation;
- For a spouse and eligible dependent - loss of coverage due to the employee's entitlement to Medicare; or
- For a dependent child - ceasing to qualify as a dependent under the Plan.

California members may be eligible for an additional 18 months of coverage, for a total of 36 months, under state law.

More detailed information will be mailed to eligible employees and covered dependents at the home address. It should be made available for all covered dependents to review. If a copy needs to be mailed to another address, that address must be provided to the HR department. The HR department must always be notified of any change of address for any covered dependent.

Coverage can only be continued for dependents that are covered at the time of the qualifying event; that is, if the spouse and/or children are not covered during employment, coverage cannot be elected at termination. Domestic Partners cannot independently select COBRA due to the dissolution of the partnership or other reasons; they can only be covered if the terminating employee selects coverage for him/herself and the partner.

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CHIP Notice

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025 Contact your State for more information on eligibility.

Alabama - Medicaid

- Website: <http://myalhipp.com/>
- Phone: 1-855-692-5447

Alaska - Medicaid

- The AK Health Insurance Premium Payment Program
- Website: <http://myakipp.com/>
- Phone: 1-866-251-4861
- Email: CustomerService@MyAKHIPP.com
- Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

Arkansas - Medicaid

- Website: [http://myarihipp \(855-692-7447\)](http://myarihipp (855-692-7447))

California - Medicaid

- Health Insurance Premium Payment (HIPP) Program Website:
- <http://dhca.ca.gov/hipp>
- Phone: 916-445-8322
- Fax: 916-440-5676
- Email: hipp@dhcs.ca.gov

Colorado - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

- Health First Colorado Website: <https://www.healthfirstcolorado.com/>
- Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
- CHP+ : <https://hcpf.colorado.gov/child-health-plan-plus>
- CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>
- HIBI Customer Service: 1-855-692-6442

Florida - Medicaid

- Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
- Phone: 1-877-357-3268

Georgia - Medicaid

- GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
- Phone: 678-564-1162, Press 1
- GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
- Phone: 678-564-1162, Press 2

Indiana - Medicaid

Health Insurance Premium Payment Program

- All other Medicaid Website: <https://www.in.gov/medicaid/>
- <http://www.in.gov/fssa/dfr/>
- Family and Social Services Administration Phone: 1-800-403-0864
- Member Services Phone: 1-800-457-45

Iowa - Medicaid and CHIP (Hawki)

- Medicaid Website: hhs.iowa.gov/medicaid/plans-programs/hawki
- Medicaid Phone: 1-800-338-8366
- Hawki Website: hhs.iowa.gov/medicaid/plans-programs/hawki
- Hawki-Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
- HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
- HIPP Phone: 1-888-346-9562

Kansas - Medicaid

- Website: <https://www.kancare.ks.gov/>
- Phone: 1-800-792-4884
- HIPP Phone: 1-800-967-4660

Kentucky - Medicaid

- Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
- <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
- Phone: 1-855-459-6328
- Email: KIHIPPPROGRAM@ky.gov
- KCHIP Website: <https://kynect.ky.gov>
- Phone: 1-877-524-4718
- Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

Louisiana - Medicaid

- Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
- Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Maine - Medicaid

- Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
- Phone: 1-800-442-6003
- TTY: Maine relay 711
- Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>
- Phone: 1-800-977-6740
- TTY: Maine relay 711

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CHIP Notice

Minnesota - Medicaid

- Website: <https://mn.gov/dhs/health-care-coverage/>
- Phone: 1-800-657-3672

Missouri - Medicaid

- Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
- Phone: 573-751-2005

Montana - Medicaid

- Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
- Phone: 1-800-694-3084
- Email: HSSHIPPProgram@mt.gov

Nebraska - Medicaid

- Website: <http://www.ACCESSNebraska.ne.gov>
- Phone: 1-855-632-7633
- Lincoln: 402-473-7000
- Omaha: 402-595-1178

Nevada - Medicaid

- Medicaid Website: <http://dhcftp.nv.gov>
- Medicaid Phone: 1-800-992-0900

New Hampshire - Medicaid

- Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
- Phone: 603-271-5218
- Toll free number for the HIPP program: 1-800-852-3345 ext. 15218
- Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey - Medicaid and CHIP

- Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
- Phone: 1-800-356-1561
- CHIP Premium Assistance Phone: 609-631-2392
- CHIP Website: <http://www.njfamilycare.org/index.html>
- CHIP Phone: 1-800-701-0710 (TTY: 711)

New York - Medicaid

- Website: https://www.health.ny.gov/health_care/medicaid/
- Phone: 1-800-541-2831

North Carolina - Medicaid

- Website: <https://medicaid.ncdhhs.gov/>
- Phone: 919-855-4100
- North Dakota - Medicaid
- Website: <https://www.hhs.nd.gov/healthcare>
- Phone: 1-844-854-4825

Oklahoma - Medicaid and CHIP

- Website: <http://www.insureoklahoma.org>
- Phone: 1-888-365-3742

Oregon - Medicaid and CHIP

- Website: <http://healthcare.oregon.gov/Pages/index.aspx>
- Phone: 1-800-699-9075

Pennsylvania - Medicaid and CHIP

- Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>
- Phone: 1-800-692-7462
- CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
- CHIP Phone: 1-800-986-KIDS (5437)

Rhode Island - Medicaid and CHIP

- Website: <http://www.eohhs.ri.gov/>
- Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

South Carolina - Medicaid

- Website: <https://www.scdhhs.gov>
- Phone: 1-888-549-0820

South Dakota - Medicaid

- Website: <http://dss.sd.gov>
- Phone: 1-888-828-0059

Texas - Medicaid

- Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
- Phone: 1-800-440-0493

Utah - Medicaid and CHIP

- Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>
- Email: upp@utah.gov
- Phone: 1-888-222-2542
- Adult Expansion Website: <https://medicaid.utah.gov/expansion/>
- Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>
- CHIP Website: <https://chip.utah.gov/>

Vermont - Medicaid

- Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
- Phone: 1-800-250-8427

Virginia - Medicaid and CHIP

- Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
- <https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
- Medicaid/CHIP Phone: 1-800-432-5924

Washington - Medicaid

- Website: <https://www.hca.wa.gov/>
- Phone: 1-800-562-3022

West Virginia - Medicaid and CHIP

- Website: <https://dhhr.wv.gov/bms/>
- <http://mywvhipp.com/>
- Medicaid Phone: 304-558-1700
- CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

Wisconsin - Medicaid and CHIP

- Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
- Phone: 1-800-362-3002

Wyoming - Medicaid

- Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
- Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

- **U.S. Department of Labor Employee Benefits Security Administration**
 - www.dol.gov/agencies/ebsa
 - 1-866-444-EBSA (3272)
- **U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services**
 - www.cms.hhs.gov
 - 1-877-267-2323, Menu Option 4, Ext. 61565

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Paperwork Reduction Act Statement

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

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

Survivors of Violence and Family Members of Victims Right to Leave and Accommodations

The Civil Rights Department (CRD) enforces California laws that protect people from discrimination, harassment, and other civil rights violations. Beginning January 1, 2025, the Fair Employment and Housing Act provides workplace protections for survivors of qualifying acts of violence, as well as people with a family member who has survived a qualifying act of violence. Protections include the right to get reasonable accommodations for the worker or their family's safety. For people who work for an employer with 25 or more employees, protections also include the right to take time off work for certain activities related to the violence. Below are answers to frequently asked questions about these protections.

General Questions

1) What is a qualifying act of violence?

Qualifying act of violence means:

- Domestic violence
- Sexual assault
- Stalking
- Acts, conduct, or a pattern of conduct involving injury or death
- Acts, conduct, or pattern of conduct involving a firearm (gun) or other dangerous weapon
- Acts, conduct, or pattern of conduct involving threats of injury or death

It does not matter if anyone has been arrested for, prosecuted for, or convicted of the qualifying act of violence.

2) Which family member(s) must experience a qualifying act of violence for me to have these protections?

- Employees may request leave or accommodations when their child, parent, grandparent, grandchild, sibling, spouse, domestic partner, or designated person experiences a qualifying act of violence. A designated person can be someone related by blood, such as an aunt or uncle, or someone who is the equivalent to a family member, such as a best friend. Employers may limit employees to taking leave for one designated person in a 12-month period.

3) Can my employer discriminate or retaliate against me or my family member for being a victim of a qualifying act of violence?

- No. An employer cannot, fire, discriminate against, or retaliate against an employee because they are, or their family member is, a victim of a qualifying act of violence.

4) I need to take time off work because I am the victim of a qualifying act of violence, or my family is the victim of a qualifying act of violence. What are my rights?

- All employees who experience a qualifying act of violence are allowed to take time off work to get a restraining order or other relief to ensure their or their child's health, safety, or welfare. Employees who work for an employer with 25 or more employees and who experience a qualifying act of violence are allowed to take leave to participate in activities for their health and safety, including seeking supportive or health services, participating in civil or criminal proceedings, moving, or caring for family injured because of a qualifying act of violence. This is also true for employees whose family member experiences a qualifying act of violence.

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5) How much time can I take off work after experiencing a qualifying act of violence?

Employees who experience a qualifying act of violence are allowed to take up to 12 weeks off work for activities protected by law. An employee whose family member dies as a result of a qualifying act of violence is also allowed to take up to 12 weeks off for these activities. An employee whose family member survived a qualifying act of violence is entitled to up to 10 days off work for activities protected by law. Up to five days may be used to help family member relocate, which includes searching for housing or enrolling children in a new school or childcare.

6) Can I use vacation, sick time, or other forms of leave to take time off work after experiencing a qualifying act of violence?

- Employees may use available vacation, paid time off, personal leave, or paid sick leave to take time off for any of the reasons described in the FAQ. If an employee is also eligible for leave under the federal Family and Medical Leave Act (FMLA) or the California Family Rights Act (CFRA), their time off resulting from a qualifying act of violence runs at the same time. That means employees are not entitled to back-to-back leave. If they use FMLA or CFRA to take time off for any of the reasons described in this FAQ, it may reduce or prevent their ability to use FMLA or CFRA for other reasons (such as after birth of a child).

7) How much notice do I have to give my employer before taking time off work after experiencing a qualifying act of violence?

- Employees must give reasonable advance notice before taking leave unless advance notice is not possible.

8) What if I have an unexcused absence from work after experiencing a qualifying act of violence?

- An employer cannot discipline or take action against the employee for an unexcused absence if the employee, within a reasonable time, provides information (called certification) that the act of violence occurred if the employer asks for it. Certification can include:
 - Police reports
 - Court records or other proof of a court appearance
 - Documentation from a supportive service provider
 - A statement signed by the employee or someone acting on their behalf
 - Other documentation verifying that a qualifying act of violence happened

Your employer is required to keep leave requests and documentation related to experiencing a qualifying act of violence confidential. The only exceptions are when federal or state law requires disclosure - for example in response to a valid court order or subpoena - or when disclosure is necessary to protect an employee's safety at work, such as calling the police to report an immediate danger. Employers must notify employees before disclosing their or their family member's information.

Safety-Related Reasonable Accommodations

9) What can I do to feel safe at work after experiencing a qualifying act of violence?

Employees who experience a qualifying act of violence, or whose family member experiences a qualifying act of violence, may request changes to their workplace (called reasonable accommodations) to ensure their safety at work. Examples of accommodations include:

- Transfer, reassignment, or a modified schedule
- Changing your work telephone number
- Permission to carry a telephone at work
- Changing your workstation
- Installing a lock
- Assistance in documenting domestic violence, sexual assault, stalking, or another qualifying act of violence that occurs in the workplace
- Implementing safety procedures
- Adjusting job structure, workplace facility, or work requirement
- Referral to a victim assistance organization

Employers may ask for certification (see question 8) to prove the accommodation request is related to a qualifying act of violence.

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Survivors of Violence and Family Members of Victims Right to Leave and Accommodations

10) Does an employer have to grant my specific accommodation request?

It depends. Employers must work with employees to brainstorm which accommodation is appropriate under the circumstances. This is called the interactive process and is a requirement under the law. When deciding whether to grant an accommodation request under this law, the employer must consider any immediate danger facing the employee or their family member.

Employers may also consider whether a requested accommodation creates an undue hardship (significant time and/or expense) for the employer or would it make the workplace unsafe for other employees. If that is the case, the employer does not have to grant the request. But the employer must work with the employee to identify alternative accommodations that still meet the employee's safety-related needs without placing an undue hardship on the employer.

11) Can I ask for more than one reasonable accommodation for my safety?

There are no limits on the type or number of accommodations an employee may request. If circumstances change and you need a new or different accommodation, let your employer know. Your employer must engage in a brainstorm with the employee (called the interactive process), considering the factors described in question 10.

Civil Rights Complaints

12) What if an employer violates the law that protects victims (and the family members of victims) of qualifying acts of violence?

If your request for leave or accommodations is denied, or you are treated negatively because you or your family member experienced a qualifying act of violence, you may file a complaint with the Civil Rights Department within three years of the employer's actions.

To File a Complaint

Civil Rights Department

calcivilrights.ca.gov/complaintprocess

Toll Free: 800.884.1684

TTY: 800.700.2320

California Relay Service (711)

Have a disability that requires accommodation? CRD can assist you with your complaint.

For translations of the guidance, visit www.cacivilrights.ca.gov/posters/employment

This guidance is for informational purposes only, does not establish substantive policy or rights, and does not constitute legal advice.

HEALTH INSURANCE MARKETPLACE



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings on your premium that you're eligible for depends on your household income. You may also be eligible for tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit, that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to the employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: Belinda Simoni (818) 546-8415 bsimoni@sccsda.org

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-23-34.pdf> for 2023.

² An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

HEALTH INSURANCE MARKETPLACE

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

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.

2026 ANNUAL PLAN NOTICES

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Southern California Conference of Seventh-day Adventists
4. Employer Identification Number (EIN):
5. Employer address: 1535 E. Chevy Chase Dr.
6. Employer phone number: (818) 546-8415
7. City: Glendale
8. State: CA
9. ZIP code: 91206-4107
10. Who can we contact about employee health coverage at this job?: Belinda Simoni
11. Phone number (if different from above):
12. Email address: bsimoni@sccsda.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - Some employees. Eligible employees are: (Benefits begin 1st of the month following 30 days)
- With respect to dependents:
 - We do offer coverage. Eligible dependents are: (Spouse and dependent children up to age 26)

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

2026 GLOSSARY OF TERMS

AD&D (Accidental Death & Dismemberment)	A Plan that provides benefits in the event of an accidental death or dismemberment (generally, an accident that results in death, loss of part of the body, or the loss of the use of part of the body).
Beneficiary	A person designated by a participant, or by the terms of an employee benefit plan, which is or may become entitled to a benefit under the plan.
COBRA	Federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) requiring certain employers that offer group health plans to provide continuation coverage to employees and their dependents who incur certain qualifying events.
Coinsurance or Cost Sharing	The portion of covered health care costs for which you are financially responsible. Coinsurance does not include deductibles or co-pays.
Co-Payment or Co-pay	A set amount you pay out of pocket for a particular service. The plan pays the balance.
Deductible	The out-of-pocket amount you must pay each plan year before the plan pays for eligible benefits.
Evidence of Insurability	Many insurance companies require prospective clients/ individuals to prove that they are in good health and are therefore good insurance risks before the company will cover them.
Explanation of Benefits (EOB)	A statement from a plan explaining what portion of a claim was paid.
Generic	Your prescription drug co-pay depends on the class or group of your prescribed medication. A generic drug generally has the lowest co-pay level. A generic drug is one that is no longer produced only under a brand name. Once a drug's patent expires, many companies can begin to manufacture "generic" versions of a previously brand-name-only drug. Generic drugs are identical to brand-name drugs in chemical makeup ("active ingredients"), usage, strength and dosage. They are regulated and approved by the FDA just like brand-name drugs; however, they are much less expensive.
HIPAA Authorization	Under HIPAA, a document that authorizes the use or disclosure of an individual's Protected Health Information by a Covered Entity for any purpose described in the document and meets specific requirements.
In-Network Provider	A provider who has contracted with a health care plan (a medical, dental or vision plan) and agreed to certain rates. In most cases, you pay less and receive a higher benefit when you use in-network providers. Check with your plan for coverage details.
Negotiated Rates	The costs for health care services negotiated between the insurance carrier and in-network health care providers. Negotiated rates are usually less than Usual, Customary and Reasonable (UCR) charges.
Non-Preferred Brand	Your prescription drug co-pay depends on the class or group of your prescribed medication. A non-preferred brand-name drug generally has the highest co-pay level because it is not on the plan's list of preferred drugs. You can find out how different drugs are classified by your plan by visiting the plan's website.
Out-of-Pocket Expenses	Co-pays, deductibles, and other expenses that are not covered by the health plan.
Out-of-Network Provider	A state-licensed health care provider who has not contracted with a health care plan (medical, dental or vision plan) and has not agreed to certain rates. In most cases, you pay more and receive a lower level of benefits when you use out-of-network providers. See your plan for coverage details.
Qualifying Life Event	Certain events which may allow you to make allowable changes to your benefits. Qualifying events include: marriage, divorce, death, birth, adoption or placement for adoption, and significant change in employment.
Reasonable and Customary (R&C) or Usual, Reasonable & Customary (UCR)	A term used in many health plans, defined as the price at or below which the majority of health-care professionals of similar expertise charge for similar procedures within a specific geographic area.

Have Questions?

You've come to the right place.

It's late after a long day of work and something comes up. Confused on your benefit plan(s)? We've all been there. Where do you turn? Right here! Already tried contacting Human Resources? If you still need more details or clarification, you may contact the appropriate program administrator directly. Maria, Claire and Ashley from Trucordia are a great starting point for any and all questions. Please see the important information below.

Benefit	Carrier	Number	Website
Medical	Blue Shield	800.393.6130	blueshieldca.com
Rx Mail Order	Blue Shield	855.206.3605	amazon.com/bluesheildca
Teladoc	Blue Shield	800.273.8255	blueshieldca.com/teladoc
Dental	Blue Shield	800.393.6130	blueshieldca.com
Vision	Blue Shield	800.393.6130	blueshieldca.com
Life/AD&D	Voya	844.472.2401	voya.com
Long Term Disability	Reliance Matrix	800.351.7500	reliancematrix.com
Voluntary Life/AD&D	Reliance Matrix	800.351.7500	reliancematrix.com
EAP	All One Health	855.775.4357	allonehealth.com/reliance-matrix
FSA	Flores	800.532.3327	flores247.com
HSA	Optum Bank	866.234.8913	optumbank.com
403(b)	Empower Retirement	855.756.4738	empower-retirement.com
Health Insurance Exchange	Covered California	800.300.1506	coveredca.com
Health Insurance Exchange	Federal Exchange	800.318.2596	healthcare.com
Belinda Simoni	HR	818.546.8415	bsimoni@sccsda.com
Concierge Team	FOY/Trucordia	818.912.7403	maria@pcfoy.com / maria.haas@trucordia.com
		800.433.5353	claire@pcfoy.com / claire.sankey@trucordia.com
		805.428.4409	ashley@pcfoy.com / ashley.clark@trucordia.com