Who May Decline Coverage?

- An eligible employee who works less than 90% of the full-time equivalent for the applicable job classification or receives less than 90% of the amount that is contributed towards an eight-hour full-time employee.
- Active employees who are enrolled in Medi-Cal must show proof of enrollment in Medi-Cal. Documentation must reflect the effective date of enrollment in Medi-Cal.
- Active employees who are enrolled in Medicare Parts A and B may decline when they are first eligible or at Open Enrollment. Evidence of Medicare enrollment is required.
- Active employees who are enrolled in TRICARE must show proof of enrollment. Documentation must reflect the effective date of enrollment in TRICARE. TRICARE rules should be reviewed before a declination is permitted.
- Active employees, who are eligible, enrolled in a Covered California medical plan and receiving a related subsidy must show proof of enrollment and subsidy.

When declining coverage in a SISC Medical plan, an active employee's participation in SISC ancillary products will be dependent upon the collective bargaining agreements in place at each district.

Unless the member will be enrolling in the WABE option, they must complete a Declination of Coverage Form. An example of the Declination of Coverage for Less Than Full-Time Active Employees and HIPAA Notification form can be found on the SISC secure web portal (SISCconnect) at **siscconnect.org**. Employees may not receive any incentives to opt-out of coverage (i.e., cash in lieu of benefits). Please contact your SISC Account Manager for further information.

According to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, an employee who declines coverage for himself/herself and his/her eligible dependents because they are covered elsewhere, must be allowed to enroll immediately upon loss of coverage. He/she must contact you within 30 calendar days of loss of coverage (60 calendar days if the loss of coverage is under a Medicaid plan or Children's Health Insurance Program) and submit evidence of "loss of coverage elsewhere" with the signed and completed enrollment or change form.

Permanent part-time employees, who work less than 90% of the full-time equivalent for the applicable job classification or receives less than 90% of the amount that is contributed towards an eight-hour full-time employee, may terminate coverage on the first of the month following a qualifying event. Please see the Qualifying Event Table for guidelines. Retro terminations will not be allowed. Part-time employees who terminate coverage may not re-enroll until the next Open Enrollment Period, unless they are eligible for a Special Enrollment Opportunity under HIPAA.

Dependents are not eligible if the retiree does not enroll. If the retiree declines or terminates coverage, they must complete a Declination of Coverage for Retirees. An example of the Declination of Coverage for Retirees form can be found on the SISC secure web portal (SISCconnect) at **siscconnect.org**.

Employees on a Board Approved Leave of Absence may decline coverage. If they decline coverage for reasons other than covered elsewhere, they may not re-enroll until they physically return to work from the approved Leave of Absence or during the next Open Enrollment Period.

Waiver of Active Benefit Enrollment (WABE Option)

WABE is an option for a district to comply with the SISC participation requirements. Employees who prefer to decline SISC medical coverage may elect this option in place of a SISC medical plan. Employees who select this option are not enrolled in a medical/Rx plan.

Employees enrolled in WABE will be reported on the monthly billing invoice. The cost of this option is the same as the single rate of the Two-Tier HSA plan for each employee group.

Employees taking this option have access to the following Added Value services:

- 24/7 Physician Line (MDLive)
- Employee Assistance Program—EAP (Anthem Blue Cross)
- Expert Medical Opinions (Teladoc Medical Experts)
- Personal Health Coaching (Vida Health)
- Biometric Screenings (when offered by district)

Districts offering WABE may continue to allow enrollment in dental, vision, and life coverages when offered by the bargaining unit. Alternatively, WABE can be offered in lieu of all coverages (Medical, Rx, Dental, Vision, and Life). However the district chooses to offer the plan, they are required to consistently enroll all members of the bargaining unit in a like manner. Consistent enrollment in WABE is subject to audit.

WABE does not count towards the maximum number of plan options. It is the responsibility of each participating district to understand the implications of offering WABE and properly communicate the details of this election to employees. If your district is interested in making WABE available as an option to your employees, please contact your Account Management Team for details and requirements.

GUIDELINES FOR RETIREES

Are Retirees Enrolled on a Separate Group Number?
Yes. Retirees must be enrolled on their own group number. They cannot be enrolled on the same group suffix with active employees (composite or three-tier rate structures). Retirees must be transferred to a retiree plan the first of the month following their date of retirement. There can be no lapse in SISC coverage. The district must request a group number from SISC to enroll retirees if one is not available on the Rate-at-a-Glance.

Retirees should be enrolled on an over-65 group number the first of the month in which Medicare Parts A and B are effective. If they are enrolled on a two-party contract, they may enroll on an over-65 group the first of the month in which Medicare Parts A and B are effective for both parties.

Is Medicare Required for Retiree Enrollment?
Yes. Retirees and their spouses/domestic partners that are Medicare eligible (65+ years of age, or less than age 65 but Medicare eligible) are required to provide proof of Medicare Parts A and B. A copy of the retiree's and spouse's/domestic partner's Medicare card must be sent to SISC prior to the first of the month in which they turn 65 (or first of the prior month if their birthday is on the 1st). Retirees must have continuous enrollment in Medicare Parts A and B while enrolled in a SISC retiree plan. Failure to maintain continuous coverage in Medicare Part A and B, or enrollment in any Medicare plan outside of SISC may result in permanent loss of coverage. Members cannot assign their Medicare to a health and/or prescription drug plan outside of SISC.

How Will I Know When a Retiree and/or Spouse/Domestic Partner are Turning 65?
SISC will notify districts by securely posting a monthly report to the SISC secure web portal (SISCconnect) approximately three (3) months prior to the member's 65th birthday. This will identify members turning 65.

As a courtesy SISC will notify employees turning age 65 by mailing a letter to them. This letter will explain to them about Medicare and when they must enroll.

It will be the district's responsibility to follow up and contact the member to remind them to submit a copy of their Medicare card and provide SISC with a copy. The premium charged to the district will be surcharged if the Medicare card is not provided timely to SISC.

What if the District does not Provide Proof of Enrollment in Medicare Parts A and B?
If proof of Medicare is not provided to SISC, the following illustrates the non-refundable surcharge that will be applied to the monthly premium of the under-65 groups. The surcharge will be applied the first of the month in which the member turns 65 until the Medicare card is produced.

2024-2025 Surcharge*	
Missing Part A	$650
Missing Part B	$650
Missing Parts A and B	$1,300

*Only members enrolled in Medicare Parts A and B can be moved to an over-65 retiree plan

What if the Retiree and/or Spouse/Domestic Partner is Missing a Part of Medicare?
If the retiree or spouse/domestic partner is under 65 and the other person is over age 65 and is missing one or both parts of Medicare, the above surcharge will be added to the two-party under-65 rate.

If both parties are 65 years of age or older and missing a part of Medicare, the surcharge will be applied for each member to the two-party under-65 rate. **The two-party contract will not be moved to an over-65 group number until all applicable Medicare cards are received.**

If the retiree is single and missing one or both parts of Medicare, the surcharge will be applied to the single under-65 rate until the retiree obtains the missing parts of Medicare and is moved to the appropriate over-65 group.