FHDA Benefits Guide

July 1 – December 31, 2012

For Active Employees & Part-time Faculty

For Retirees, Surviving Spouses/ Domestic Partners & COBRA Enrollees

General Plan Information

FOOTHILL-DE ANZA
Community College District

Where to Go for Information & Assistance

■ MEDICAL HEALTH PLANS

FHDA Benefits Website: http://hr.fhda.edu/benefits

CalPERS Retirement Website: http://www.calpers.ca.gov/index.jsp?bc=/member/retirement/home.xml

CalSTRS Retirement Website: http://www.calstrs.com

CalPERS Health Carriers:

HMOs —

Blue Shield Access+ Blue Shield Net Value • Blue Shield 65 Plus	Phone: (800) 997-3770	www.blueshieldca.com
Kaiser Permanente	Phone: (800) 464-4000	www.kp.org

PPOs —

Anthem Blue Cross (PERSCare/Choice/Select)	Phone: (877) 737-7776	www.anthem.com/ca/calpers

FHDA Benefits Unit:
Foothill-De Anza Community College District
Attn: Benefits Unit
12345 El Monte Road • Los Altos Hill, CA 94022
Phone: (650) 949-6224 • Fax: (650) 949-2831
E-mail: mybenefits@fhda.edu

CalPERS Health Benefits Division — Phone: (888) 225-7377 — www.calpers.ca.gov

■ PRESCRIPTIONS

CVS Caremark Rx —
PERSCare/Choice/Select Phone: (877) 542-0284 www.caremark.com/calpers

■ DENTAL/VISION

Delta Dental PPO Phone: (888) 335-8227 www.deltadentalins.com
Vision Service Plan (VSP) Phone: (800) 877-7195 www.vsp.com

■ RETIREE SUPPORT

Secova collects and submits required health plan election and documentation forms for retirees, and provides support and assistance.

Support Services Available April 15 – May 15, 2012, Monday – Friday, 8 a.m. – 8 p.m.

SECOVA Customer Service
Phone: (866) 364-2594
eFax: (866) 635-4606
E-mail: fhda.retireebenefits@secova.com

SECOVA Retirees Support
Attn: RETIREES SUPPORTING SERVICES
5000 Birch Street, West Tower, Suite 1400, Newport Beach, CA 92660

Table of Contents

Table of Contents

DISCLAIMER — The information in this brochure is a general outline of the benefits offered under the Foothill-De Anza Community College District's benefits program. Specific details and plan limitations are provided in the Evidence of Coverage (EOC), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The EOC and plan documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

1 Introduction

The CalPERS Health Program, General Open Enrollment Information, Open Enrollment Workshop Flyers, Payment Policy

The CalPERS Health Program

In March 2012, the Foothill-De Anza Community College District and the Joint Labor-Management Benefits Council (JLMBC) — composed of the five bargaining units, and representatives of the managers, confidential employees and retirees — agreed to change the medical benefits coverage from United Healthcare to the CalPERS Health Program.

The CalPERS Health benefit plans operate on a calendar year cycle. This means the District will transition to a calendar year basis for our benefit plans. Following an initial transition open enrollment starting April 15, 2012 for the period of July – December, 2012, open enrollment will be scheduled each fall instead of each spring. The next open enrollment period for CalPERS coverage will be in Fall 2012, and the effective dates of the next benefit period will be January 1, 2013 through December 31, 2013.

Open Enrollment for the Initial Six-Month Period is April 15, 2012 – 5 p.m., May 15, 2012
We will be holding workshops to inform you about the plan details and to assist you with enrolling. Workshop flyers for both active employees and part-time faculty and retirees, their spouses/domestic partners, surviving spouses/domestic partners and COBRA enrollees are included in this booklet. It is imperative that you meet the final deadline to ensure coverage.

Six New CalPERS Benefit Plan Choices
The CalPERS Health plans provide more choices for you. Instead of the three current plans (Kaiser, United Healthcare EPO and United Healthcare PPO, including out-of area plans), CalPERS Health offers six plans, as follows:

- **Three HMOs:** Kaiser, Blue Shield Access+ and Blue Shield NetValue
- **Three PPOs:** PERS Care, PERS Choice and PERS Select

Dental and Vision Coverage

Dental and vision plans will continue with the same provisions for coverage as the dental and vision plans currently in effect for the 2011 – 2012 plan year (Delta and VSP).

For active employees: Under the cafeteria plan (see Active Employees section), employees will be required to either select or opt out of dental/vision coverage as part of their online enrollment process.

For retirees: The dental/vision coverage is included when a retiree successfully completes his/her election for medical plan coverage. Retirees who do not select a medical plan will not have dental and vision coverage.

Prescription Coverage: Transition from Medco to CVS Caremark

The CalPERS Health Program uses CVS Caremark as its medical prescription provider. All active employees and retirees will make a transition from Medco to Caremark beginning July 1, 2012.

Prescription Refills

If you have refills available after July 1, 2012, you must request a transfer to CVS Caremark. Call CVS Caremark at **877-542-0284** or use the website **www.caremark.com/calpers.**

Specialty Pharmacy

Beginning July 1, 2012, members currently using specialty medications will be contacted by CVS Caremark to assist in the transition from the United Healthcare Specialty Pharmacy Program to CVS. For questions regarding specialty medications, please call CVS Caremark toll free at **877-542-0284** to reach the CVS Caremark Specialty Pharmacy.

The CVS Caremark Retail Network

CVS Caremark's network contains over 64,000 pharmacies consisting of all major chains and a large number of independent pharmacies. You may call CVS Caremark toll-free at **877-542-0284** to locate a participating pharmacy.

Direct Reimbursement (Paper) Claims

If you have direct reimbursement (paper) claims prior to July 1, 2012, please forward them to Medco for processing.

After July 1, 2012, CVS Caremark will be responsible for processing direct reimbursement (paper) claims. Please call CVS Caremark toll free at **877-542-0284** for assistance.

Payment of Monthly Contributions

Employee and retiree monthly premium contributions are due on or before the first of the month, for each month of coverage. Monthly contribution due dates are not changeable; that is, the due date cannot be altered for any plan subscriber.

Loss of coverage may occur when the plan subscriber's account is in default in accordance with Foothill-De Anza Community College District and CalPERS procedures on employee and retiree monthly contributions. If coverage is lost, the effective date of loss of coverage shall be the last day of the month for which coverage was fully paid, including any financial penalties. All medical expenses/benefit charges incurred by the subscriber and his/her dependents, if any, after loss of coverage, become the subscriber's responsibility.

Plan subscribers may re-enroll for benefits coverage in accordance with District and CalPERS rules and regulations (currently with the next plan year following successful enrollment during the applicable open enrollment period).

Please see http://hr.fhda.edu/benefits or contact the District Office of Human Resources, Benefits Unit, at the address below for additional information.

E-mail: MyBenefits@fhda.edu
Phone: (650) 949-6224
In Person or by Mail: Foothill-De Anza Community College District
Office of Human Resources/Benefits Unit
12345 El Monte Road
Los Altos Hill, CA 94022

2 Active Employees

Online Benefits Enrollment

Enroll Online Using www.iElect.com

Full-time, Regular and Probationary Employees and Currently Enrolled Part-time Faculty

All benefit-eligible employees and currently enrolled part-time faculty must successfully complete their benefits enrollment using iElect, an online benefits election system at www.iElect.com, to continue or initiate benefits coverage effective July 1, 2012 – December 31, 2012.

The Open Enrollment window for this six-month period is April 15, 2012 – 5 p.m., May 15, 2012. Meet the Deadline!

FIVE (5) STEPS TO SUCCESS!

Prior To April 15, 2012

■ **Step 1: Know Your LOGIN Number** (Required to log in to www.iElect.com)

- Your LOGIN number is the last 4 digits of your Social Security Number (SSN#), immediately followed by the birth month, date and year as follows:
- SSN#MMDDYYYY
- *For example:*
  Last four digits of your SSN# 5555 +
  Your birth date of Jan. 31, 1975 (MMDDYYYY) =
  Your LOGIN Number — 555501311975

■ **Step 2: Receive Your PIN Number** (Required to log in to www.iElect.com)

Secova, the district's online benefits enrollment administrator, will mail your customized Personal Identification Number (PIN) to your home address prior to April 15, 2012. You will need this PIN to access the iElect online enrollment system and make your benefits elections. This unique PIN provides the same authority as your signature. It certifies that all the information is complete and true, and authorizes your 2012 benefit election and payroll deductions.

IMPORTANT: Keep your PIN in a handy place for future use. This PIN will allow you to access the iElect home page and view all of the benefit information, confirm your benefit plan elections and coverage, and have easy access to pertinent websites.

From April 15, 2012 – 5 p.m., May 15, 2012

■ **Step 3: Enroll Online Using iElect at *www.iElect.com***

- Log on to ***www.iElect.com***.
- Enter Employer: FHDA
- Enter LOGIN: SSN#MMDDYYYY
- Enter PIN: (as provided by Secova)

Follow the instructions provided by Secova's PIN Notification Letter and as requested by each step in the iElect website.

From April 15, 2012 until 5 p.m. on May 15, 2012, you'll be able to make your benefits election 24 hours a day, seven days a week by logging on to ***www.iElect.com***.

■ **Step 4: Confirm Your Benefits Election**

To complete your benefits election online, you must click the "PLEASE CONFIRM" button at the end to activate your benefits election for the period of July 1, 2012 – December 31, 2012. Caution: failure to complete the

election process (by clicking the "PLEASE CONFIRM" button) will result in loss of coverage effective July 1, 2012.

Recommended: You may wish to save a copy of your Temporary Confirmation Statement on your desktop before exiting the system, or print a hard copy for your records.

Verify Your Enrollment
You will receive an e-mail within 24 hours of enrolling and confirming your selection and notifying you that your enrollment was confirmed.

Final Benefits Confirmation: You will receive an official benefits confirmation statement from Secova (FHDA's Benefits Enrollment Support Services Provider) by May 31, 2012.

■ Step 5: Required Documentation for Adding a Dependent

You must provide documentation for each added dependent to the District Office of Human Resources/Benefits Unit. For example:

- A marriage license/domestic partner affidavit
- A birth certificate or legal adoption papers
- A copy of a Social Security card

All required documentation must be submitted to the District Office of Human Resources /Benefits Unit by **5 p.m., May 15, 2012.** Failure to provide the required documentation may result in loss of coverage.

THINGS YOU SHOULD KNOW

MAKING CHANGES To Your Benefits Election DURING Open Enrollment
If you need to make a change to your confirmed benefits election during Open Enrollment, you may access and log on to www.iElect.com and repeat the process.

Remember: once you initiate a change in your benefits election, you must complete your benefits election and click the "PLEASE CONFIRM" button at the end to activate your benefits election change.

NO CHANGES To Your Benefits Election AFTER Open Enrollment
Once Open Enrollment is closed, you will not be allowed to make a change to your benefit plan choices, including dependent coverage, until the next open enrollment for plan year 2013 (January 1 – December 31, 2013).

CHANGES to Dependent Coverage After Open Enrollment FOR QUALIFYING CHANGE In Family Status
Exceptions to make a change to your dependent coverage may be allowed only if you have a qualifying "change in family status."

For all plans, it is your responsibility to notify the District of any changes regarding eligibility. Failure to act in a timely manner may disqualify you from receiving District-paid benefits, and/or deny your benefits claim(s). You are required to notify the District Office of Human Resources/ Benefits Unit in writing within thirty-one (31) days whenever there is a change in dependent status, and within ten (10) days if there is a change in address. Your prompt cooperation in this matter is greatly appreciated.

DON'T HAVE ACCESS TO A COMPUTER ?

Employees who have no access to a computer or the Internet from home may use a District computer—at their worksite, during the iElect sessions or at the District Office of Human Resources/Benefits Unit—to make their benefits election online.

If for any reason an employee is unable to easily access the Internet, he/she should contact the Benefits Unit immediately for assistance.

E-mail: MyBenefits@fhda.edu
Phone: (650) 949-6224
In Person or
By Mail: Foothill-De Anza Community College District
Office of Human Resources/Benefits Unit
12345 El Monte Road
Los Altos Hill, CA 94022

PAYROLL DEDUCTIONS

By confirming your election on-line, you authorize changes to your account, including any required payroll deductions.

NEED HELP ENROLLING?

Please attend one of the iElect sessions offered during Open Enrollment or contact the District Office of Human Resources/Benefits Unit for assistance.

E-mail: MyBenefits@fhda.edu
Phone: (650) 949-6224
In Person or
By Mail: Foothill-De Anza Community College District
Office of Human Resources/Benefits Unit
12345 El Monte Road
Los Altos Hill, CA 94022

NEED SPECIFIC INFORMATION ABOUT THE MEDICAL BENEFIT PLANS?

If you have questions about a specific benefit plan or need to verify a contracted medical provider, please speak with a representative during the Open Enrollment sessions, review information online at the Benefits Unit website or contact the insurance carrier directly. Detailed plan documents and carrier contact information is available on the Benefits Unit website at http://hr.fhda.edu/benefits.

FHDA 2012 BENEFITS ENROLLMENT WORKSHOPS

FOR ACTIVE ELIGIBLE EMPLOYEES & CURRENTLY ENROLLED PART-TIME FACULTY

Presented by the Following Representatives:
CalPERS, Kaiser, Blue Shield of CA, Anthem Blue Cross & CVS Caremark
Foothill-De Anza District Benefits

FOR THE PERIOD JULY – DECEMBER, 2012

Open Sessions			
What's Happening	**Date**	**Time**	**Location**
Active Eligible Employees and Currently Enrolled Part-time Faculty: **Full Presentation**	Mon., April 30, 2012 Tue., May 1, 2012 Wed., May 2, 2012	11 a.m. – 3 p.m. 11 a.m. – 2 p.m. 11 a.m. – 2 p.m.	Foothill College Campus Center Toyon Room De Anza College Hinson Campus Center Conference Room A & B De Anza College Hinson Campus Center Conference Room A & B
Night Shift (Custodian): **Individual Q&A Assistance**	Fri., May 4, 2012	4:15 p.m. – 5:30 p.m.	De Anza College Hinson Campus Center Fireside Room
Prospective (and Current) Retirees: **Full Presentation**	Fr.i, April 20, 2012	11 a.m. – 2 p.m.	De Anza College Hinson Campus Center Conference Room A & B
Register/Sign-In at Least 15 Minutes Before Presentations			

For Individual Assistance *iElect Online Enrollment Assistance*			
Mon., May 7, 2012	11:30 a.m. – 1 p.m.	LCW-16 Computer Lab	De Anza College
Tues., May 8, 2012	11:30 a.m. – 1 p.m.	LCW-16 Computer Lab	De Anza College
Wed., May 9, 2012	11:30 a.m. – 1 p.m.	LCW-16 Computer Lab	De Anza College
Thur., May 3, 2012	11:30 a.m. – 1 p.m.	KCI, Room 4006	Foothill College
Thur., May 10, 2012	11:30 a.m. – 1 p.m.	KCI, Room 4006	Foothill College
Mon., May 14, 2012	11:30 a.m. – 1 p.m.	KCI, Room 4006	Foothill College

Online Open Enrollment Period April 15, 2012 - May 15, 2012
Meet the Deadline!

WORKSHOP AGENDA

Information About the CalPERS Heath Care Plans
For the Period July 1, 2012 to December 31, 2012

Agenda Includes:

- Presentations – new plan choices
- Which medical plan is the right one for you?
- Employee contribution rates
- The new "Cafeteria Plan" (IRS Section 125)
- Dental and vision coverage
- Transition of prescriptions from Medco to CVS Caremark
- Spouse/Domestic partner and dependent coverage
- Disabled dependent child(ren) coverage
- Flexible Spending Accounts (FSAs): health and dependent care expenses
- How to make open enrollment changes within the open enrollment period
- Layoff – continuation of coverage provisions
- Tips on how to maximize your benefits
- Voluntary benefits (.e.g. Supplemental Life Insurance)
- Part-time faculty instructions

COMPLETING YOUR ONLINE ENROLLMENT

Dates & Steps:

- Online open enrollment is **April 15 – 5 p.m. on May 15, 2012** for the new FHDA heath care plan options from CalPERS
- PIN number (for you to initiate online enrollment) mailed to your home the week of April 9, 2012
- Elect one of the following six CalPERS heath care plans below via "iElect" (online enrollment)

  HMO Choices: KAISER, Blue Shield Access+ or Blue Shield NetValue
  PPO Choices: PERS Care, PERS Choice or PERS Select

- **All Active Eligible Employees and Currently Enrolled Part-Time Faculty:**

  You must successfully complete online enrollment to continue benefits effective July 1, 2012

  Online enrollment must be completed no later than **5 p.m., Tuesday, May 15, 2012**

Benefits Website: http://hr.fhda.edu/benefits/

Cafeteria Plans (For FHDA Active Employees Only)

What is a Cafeteria Plan?

A Cafeteria Plan gives employees an opportunity to choose from a menu of benefits consisting of cash (often in the form of regular pay) and certain non-taxable benefits (for example, health insurance benefits).

Cafeteria Plans also allow employees to pay their contributions towards benefits, such as premium payments and flexible spending accounts (FSA) on a pre-tax basis.

Cafeteria Plans must meet the requirements of Internal Revenue Code § 125 and regulations issued by the IRS. These IRS regulations:

- Govern employee eligibility, enrollment, type of benefits offered, funding, and more; retirees are not eligible to participate in a Cafeteria Plan;
- Require plans to maintain a written plan document that provides a detailed description of the adopted plan; and
- Require certain reporting and testing requirements.

Additional regulations come from other sources, including the Department of Labor, the Treasury Department, the Center for Medicare and Medicaid, and other federal and state mandates.

The Cafeteria Plan with CalPERS

Section 125 Cafeteria Plans also allow for a "Full Flex" Benefit Plan where employees are allowed to choose from several plan benefits. This type of Cafeteria Plan includes the use of "Benefit Credits" and "Price Tags" that are determined actuarially.

FHDA's new plans under CalPERS will include this Full Flex provision and provide each employee with Benefit Credits that can be applied towards the cost of each benefit. The cost, or Price Tag, of a benefit will be deducted from the employee's Benefit Credits.

If the employee chooses benefits that have Price Tags exceeding his/her Credits, the remainder is deducted from the employee's paycheck on a pre-tax basis.

This method allows FHDA to meet the contribution requirements of CalPERS while also adhering to the FHDA Joint Labor Management Benefit Council (JLMBC) principles, including cost-sharing similar to the current structure.

The Full Flex Cafeteria Plan was intentionally designed to be very simple initially. In the future, additional benefit options may be provided that will allow employees to choose from an array of benefits best suited to their needs.

Employee/Retiree Monthly Contribution Rates Effective July 1, 2012 – December 31, 2012

2012 CalPERS PLAN*	Per Month Contribution
PERS Care / PERS Care-Medicare	
E	$427
E + 1	$853
E + family	$1,280
PERS Choice / PERS Choice Medicare	
E	$117
E + 1	$233
E + family	$350
PERS Select / PERS Select-Medicare	
E	$65
E + 1	$130
E + family	$195
Blue Shield Access+ / Blue Shield Access+ - Medicare	
E	$240
E + 1	$480
E + family	$720
Blue Shield NetValue / Blue Shield NetValue-Medicare	
E	$162
E + 1	$324
E + family	$486
Kaiser CA / Kaiser CA-Medicare	
E	$70
E + 1	$140
E + family	$210

***** *Includes Dental and Vision*

Part-time Faculty Monthly Contribution Rates Effective July 1, 2012 – December 31, 2012

CalPERS PLAN	Per Month Contribution Load = .400 – .499	Per Month Contribution Load = .500 – .670
PERS Care		
E	$786	$698
E + 1	$1,571	$1,396
E + family	$2,042	$1,814
PERS Choice		
E	$330	$243
E + 1	$661	$485
E + family	$859	$631
PERS Select		
E	$244	$156
E + 1	$487	$312
E + family	$634	$406
Blue Shield Access+		
E	$467	$380
E + 1	$935	$759
E + family	$1,215	$987
Blue Shield NetValue		
E	$368	$280
E + 1	$736	$560
E + family	$957	$728
Kaiser CA		
E	$305	$195
E + 1	$610	$391
E + family	$794	$508

Flexible Spending Accounts, Supplemental Group Term Life Insurance

Full-time Regular and Probationary Employees

FLEXIBLE SPENDING ACCOUNTS (FSA)

Definition: Flexible Spending Accounts (FSA) provide a simple way to gain tax savings. Participating in an FSA allows you to contribute, on a pre-tax basis through payroll deduction, to a health care and/or dependent care account. When you incur eligible expenses, as defined by the IRS, you may receive tax-free reimbursement from your account(s).

Plan Year: The election is for the period between July 1, 2012 through December 31, 2012. Eligible expenses must be incurred during this period, regardless of when the service is billed or paid.

Contributions: Contributions for FSA's are deducted from each paycheck on a pre-tax basis. The annual contribution limits associated for each account are:

1. **Health Care Account (HCA):**
   $250 minimum; $1,500 maximum

   - Please note that employee monthly health plan contributions towards healthcare costs are not included under this plan; do not include these premium contributions in your estimate for your HCA.
   - Any unused funds remaining in your HCA account after the close of the plan year are forfeited as required by the IRS.
   - For a detailed list of eligible expenses, please refer to *IRS Publication 502 (Health Care Expenses*) available online at http://irs.gov.
   - Your first payroll deduction will occur on July 31, 2012.

2. **Dependent Care Account (DCA):**
   $250 minimum; $2,500 maximum
   Note: (DCA allows $2,500 if married and filing separate tax returns)

   HCA funds and DCA funds must remain separate. Contributions made to one account cannot be used to reimburse expenses for the other account.

   The IRS provides for a maximum of $5,000 in combined contributions to any DCA, per family, per calendar year. Any unused funds remaining in your DCA account after the close of the plan year are forfeited as required by the IRS.

   Pre-tax deductions can be used to reimburse any child (under 13 years old) and dependent (elder) care expenses that would otherwise be eligible for a tax credit, as defined by the IRS. The care ***provider*** cannot be your child under age 19, or anyone else you or your spouse can claim as a dependent for tax purposes. You will be required to report the Tax ID Number or Social Security Number of your dependent care provider. For a detailed list of eligible expenses refer to IRS Publication 503 (Child and Dependent Care Expenses), available online at http://irs.gov. Your first payroll deduction will occur on July 31, 2012.

How to Make FSA Elections:

- Prior to or during Online Open Enrollment, review your current FSA elections
- Use FSA Worksheets available online at: http://hr.fhda.edu/ to estimate your eligible expenses for the plan year
- Make your elections at http//www.ielect.com for each plan year. It is not automatically renewed.

FSA Election Changes During the Plan Year:
You can only make election changes during the year within 31 days of a qualifying status change. There are two types of qualifying changes: (1) Family Status Changes and (2) Employment Status Changes.

Deadline for Submission to Request Reimbursement:
The deadline to apply for FSA reimbursement of expenses incurred for the ***current*** Plan Year (July 1, 2011 – June 30, 2012) is September 30, 2012. The deadline for period of July 1 – December 31, 2012 is March 31, 2013. Failure to incur expenses within the plan year or to submit claims for reimbursement by the deadline will result in a forfeit of the balance of the account(s) per IRS regulation. ***Please review the*** **FSA Plan Summary of Description** ***online for more details.***

SUPPLEMENTAL TERM LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT PLAN
(Underwritten by HARTFORD Life Insurance Company)
Group # 677313

The minimum coverage for an employee's supplemental life policy is *$50,000,* and for the spouse/domestic partner is *$25,000.* However, the maximum supplemental term life coverage for the employee and spouse/domestic partner coverage is *$150,000.* The dependent children coverage will remain unchanged at *$10,000*.

As a reminder, Hartford enforces the 12-months premium over 12 equal payroll deductions. To avoid late payment for 10- and 11-month employees, the District will apply a double (11-month employee: July or August + September) and/or triple (10-month employee: July/August/September) premium deduction at the earliest payroll cycle. This action will bring the account up-to-date with the payment schedule.

Existing policyholders will be defaulted to the same level of coverage and premium for the period of July – December 2012. Therefore, to maintain your existing coverage, you do not need to fill out any paperwork but you must verify your current level of coverage amount online via Online Open Enrollment at www.iElect.com.

To enroll or withdraw from the voluntary term life program, select new coverage, or make a change to your current policy. You must:

- Make your selection online via www.iElect.com.
- Complete both the *HARTFORD Life Insurance Application* and *Evidence of Insurability (EOI)* forms **by the deadline of May 15, 2012.**

Note: Both forms can be downloaded online during your election process via iElect or access District's Benefits website: http://hr.fhda.edu/benefits/.

Failure to complete both applications will automatically disqualify you from the Hartford underwriting application process.

How to pay for your supplemental life premium?

Your payroll deductions may change if you are in a different age bracket on July 1, 2012. You can view premium rates on the iElect website. Premium rates are calculated on a monthly basis and payroll deductions will be deducted accordingly over the six pay periods.

Please refer to the *Evidence of Coverage* or the *Summary Plan Description* for details of benefit limitations, exclusions, and general program parameters.

3 Retirees

and Surviving Spouses, Dependents, & COBRA Enrollees

Paper Forms Benefit Enrollment

All Retirees, Surviving Spouses and COBRA Enrollees
All retirees, surviving spouses and COBRA enrollees must successfully complete their benefits enrollment using the paper forms provided by CalPERS (mailed to home addresses) to continue or initiate healthcare benefits coverage effective July 1, 2012 – December 31, 2012.

The Open Enrollment window for this six-month period is April 15, 2012 – 5 p.m., May 15, 2012. Meet the Deadline!

FOUR (4) STEPS TO SUCCESS!

Prior To April 15, 2012

■ **Step 1: Gather Your Documents**

CalPERS will mail a package of the required forms and documents to your home, including a list of information you will be required to submit to verify your status and the status of your spouse and/or dependents (e.g. Medicare eligibility, marriage certificate, disabled child certification, etc.).

From April 15, 2012 – 5 p.m., May 15, 2012

■ **Step 2: Complete Your Required Forms**

Follow the instructions provided by the CalPERS letter and complete each form that applies to your situation.

■ **Step 3: Double-Check Required Documentation for Spouse/Domestic Partner and Dependents**

If you wish to cover a spouse/domestic partner or a dependent, you must provide documentation for each dependent (e.g. marriage license, domestic partner affidavit, legal divorce decree signed by the judge, birth/death certificate, or legal adoption papers and copy of Social Security card).

■ **Step 4: Submit All Completed Forms and Required Documents to Secova**

To complete your benefits election, you ***must*** submit all completed forms and required documentation to Secova to activate your benefits election for the period of July 1, 2012 – December 31, 2012. All forms and documents ***must be received by Secova*** (FHDA's Benefits Enrollment Support Services Provider) ***not later than 5 p.m., May 15, 2012.*** Failing to complete the forms and ensure Secova receives the forms and documents by the deadline may result in loss of coverage effective July 1, 2012.

Recommended: Submit your forms and documents well before the deadline by facsimile (fax) or certified mail which will provide you with a record of your submission and give you ample time to resolve any concerns, such as missing documents or incomplete forms. Why? Because unresolved issues could cause you to lose coverage.

Verify Your Enrollment
Secova will mail a confirmation of receipt of documents to you within 72 hours of receipt. You may also call Secova at 1-866-364-2594, to confirm receipt and verify your enrollment.

Official Benefits Confirmation: You will receive an Official Benefits Confirmation Statement from Secova by May 31, 2012.

THINGS YOU SHOULD KNOW

Making Changes to Your Benefits Election During Open Enrollment
If you need to make a change to your benefits election during Open Enrollment, you **must contact** Secova **and** repeat the process.

NO CHANGES to YOUR Benefits Election AFTER Open Enrollment
Once Open Enrollment is closed you will not be allowed to make a change to your benefit plan choices, including dependent coverage, until the next open enrollment in Fall 2012 for the next plan year (January 1 – December 31, 2013).

Changes to DEPENDENT Coverage AFTER Open Enrollment for QUALIFYING CHANGE IN FAMILY STATUS
Exceptions to make a change to your dependent coverage are allowed only if you have a qualifying "change in family status."

For ***all*** plans, it is your responsibility to notify the District of any changes regarding eligibility. Failure to do so in a timely manner may disqualify you from receiving District-paid healthcare benefits. You are required to notify the District Office of Human Resources/Benefits Unit in writing **within thirty-one (31) days** whenever there is a change in dependent status, and **within ten (10) days** if there is a change in address. Your prompt cooperation in this matter is greatly appreciated.

RETIREMENT WARRANT DEDUCTIONS

By completing your enrollment forms, you authorize changes to your benefits election for the period July 1, 2012 – December 31, 2012, including any required deductions from your pension warrant (retirement check) or bank account (for amounts still owed).

NEED HELP ENROLLING?

Please attend one of the special assistance sessions offered during Open Enrollment or contact Secova Retiree Support Services for assistance.

Secova Retirees Support Services:
(Effective April 15 – May 15, 2012,
Monday – Friday, 8 a.m. – 8 p.m.)

Phone: (866) 364-2594
eFax: (866) 635-4606
E-mail: fhda.retireebenefits@secova.com
By Mail: Attn: RETIREES SUPPORTING SERVICES
5000 Birch Street, West Tower, Suite 1400
Newport Beach, CA 92660

NEED SPECIFIC INFORMATION ABOUT THE MEDICAL BENEFIT PLANS?

If you have questions about the benefit plans or need to verify that a particular medical provider is included for coverage, please speak with a representative during the Open Enrollment sessions, review information online at the Benefits Unit website or contact the insurance carrier directly. Detailed plan documents and carrier contact information is available on the Benefits Unit website at http://hr.fhda.edu/. You may also contact the District Office of Human Resources/Benefits Unit for assistance.

E-mail: MyBenefits@fhda.edu
Phone: (650) 949-6224
In Person
or By Mail: Foothill-De Anza Community College District
Office of Human Resources/Benefits Unit
12345 El Monte Road
Los Altos Hill, CA 94022

FHDA 2012 BENEFITS ENROLLMENT WORKSHOPS

FOR RETIREES, SURVIVING SPOUSES & COBRA ENROLLEES

Presented by the Following Representatives:
CalPERS, Medicare, Kaiser, Blue Shield of CA, Anthem Blue Cross & CVS Caremark
Foothill-De Anza District Benefits

Reserved for Current & Prospective Retirees (and Surviving Spouses & COBRA Enrollees)

Workshop Location: DE ANZA COLLEGE

Hinson Campus Center, Conference Rooms A & B

What's Happening	Date	Time	Who Will be There
Full Presentation*	Fri., April 20, 2012	11 a.m. – 2 p.m. (Register/Sign-in by 10:45 a.m.)	CalPERS, Health/Rx Plan Reps & *Medicare*
Individual Q&A Only	Tues., May 1, 2012	2 p.m. – 4 p.m.	CalPERS & Health/Rx Plan Reps Only
Individual Q&A Only	Wed., May 2, 2012	2 p.m. – 4 p.m.	CalPERS & Health/Rx Plan Reps Only

* If you are unable to attend, we encourage you to attend one of the following Open Sessions:
Mon, Apr. 30, 2012: 11 a.m. – 3 p.m., Foothill College, Campus Center Toyon Room
Tue, May 1, 2012: 11 a.m. – 2 p.m., De Anza College, Hinson Campus Center, Conference Rooms A & B
Wed, May 2, 2012: 11 a.m. – 2 p.m., De Anza College, Hinson Campus Center, Conference Rooms A & B

- The enrollment period is **April 15 – 5 p.m. on May 15, 2012** for the new FHDA heath care plan options from CalPERS
- Your election for one of the following six CalPERS heath care plans is by mailed/faxed paper form

  HMO Choices: KAISER, Blue Shield Access+ and Blue Shield NetValue
  PPO Choices: PERS Care, PERS Choice, PERS Select
- Your CalPERS completed enrollment forms *and* required documentation must be received by SECOVA no later than **5 p.m., Tuesday, May 15, 2012**
- Please see reverse side for additional information about the workshop and required election documentation

Open Enrollment Period April 15 – 5 p.m. on May 15, 2012
Meet the Deadline!

WORKSHOP AGENDA

Information About the CalPERS Heath Care Plans
Effective July 1, 2012 to December 31, 2012.

Agenda Includes:

- Presentations: The New Plan Choices
- Which medical plan is the right one for you?
- Dental and vision coverage
- New contribution rates
- Required deductions of retirees/survivors' monthly premiums from the annuitants' warrants
- SECOVA: DirectBill service for retirees/survivors
- Quarterly Medicare premium Part B refunds
- Surviving spouses and COBRA administration changes
- How to make open enrollment changes within the open enrollment period
- Tips on how to maximize your benefits

REQUIRED CALPERS FORMS & DOCUMENTS

Documents You Will Need to Complete Your Enrollment

FOR RETIREES AND SURVIVING SPOUSES:

- Everyone:
  - CalPERS Health Benefit Plan Enrollment (Form HBD-30)
  - Electronic funds Transfer authorization for:
    - Monthly reimbursement for when CalPERS has over-collected from your annuity
    - Monthly billing for when CalPERS has under-collected from your annuity
    - Monthly billing through DirectBill (for non-pensioners)
    - Quarterly Medicare reimbursement
- If Applicable:
  - Medicare ID card or Certificate of Medicare Status (Form PERS 08M0021DMC)
  - If Enrolling Spouse/Domestic Partner or Dependents:
    - Marriage/Domestic Partnership Certification (submit one):
      - Marriage Certificate (photo copy okay)
      - Same-Sex Domestic Partner Certificate (photo copy okay)
      - Notarized Affidavit of Marriage (Form HBSD-1965) (Notarized original required)
  - If Enrolling a Dependent:
    - Affidavit of Parent-Child Relationship (Form HBD-40)
  - If Enrolling a Disabled Dependent (submit all three)
    - Affidavit of Parent-Child Relationship (Form HBD-40)
    - Questionnaire for Disabled Dependent Benefits (Form HBD-98)
    - Physician's certified Medical Report for Disabled Dependent Children (Form HBD-34)
- Everyone: Return all paperwork to SECOVA (*not* FHDA, *not* CalPERS)

FOR COBRA ENROLLEES:

- Everyone:
  - CalPERS Health Benefit Plan Enrollment (Form HBD-30)
  - COBRA Election (Form HBD-85)
- Everyone: Return all paperwork to FHDA (not SECOVA, not CalPERS)

Electronic Funds Transfer

Required to Initiate or Continue Health Benefits Effective July 1, 2012

Authorizing Electronic Funds Transfer

All retirees who wish to initiate or continue health insurance coverage through one of the FHDA-sponsored CalPERS Health plans are required to complete and submit ***by May 15, 2012*** **:**

1. The enclosed *Electronic Funds Transfer* form, along with
2. A voided check or savings deposit slip from the bank account to be used for billing and reimbursements.

Submitting the EFT form and voided check will authorize required deposits to, and withdrawals from, the retiree's bank account for the monthly contribution associated with the retiree's elected benefits plan effective July 1, 2012.

(**NOTE:** You will not receive any paper invoices going forward; all transactions will be handled electronically)

On or about the first of each month funds will be automatically deposited to, or withdrawn from, the retiree's bank account, based on the difference between the monthly health plan premium the retiree paid by deduction from his/her retirement check and the monthly contribution actually required of the retiree.

What if I Already Have EFT Authorization with United Healthcare Benefit Services?

If you have already authorized United Healthcare Benefit Services to recover payments through the EFT process, service will stop as of June 30, 2012. All prior authorizations for EFT processing will discontinue effective June 30, 2012.

You must complete a new EFT form and submit it to Secova to authorize deposits to, and withdrawals from, your checking/saving account.

What if I Change Banks?

If you change banks, you must notify Secova immediately to avoid non-payment concerns.)

Why is a Deduction Made from My Retirement Check?

In accordance with the requirements for participating in the CalPERS Health plans, all retirees who are deemed annuitants with CalPERS/CalSTRS (i.e. receiving a retirement check) are required to contribute their premium contributions to the cost of their health plans by deduction from their PERS or STRS retirement checks. The District then determines the difference between the deduction from the retiree's retirement check and the amount subsidized by the District and deposits to, or withdraws from, the retirees authorized bank account.

What If My Retirement Check Doesn't Cover My Monthly Contribution for My Health Plan?

Payment of the retiree's responsible portion is due in full on the first of the EFT month. In the event a deduction from the retiree's retirement check is insufficient, a withdrawal from the retiree's bank account is required. Funds must be available on the date of withdrawal in order to fulfill the monthly contribution due.

What if I Am a Surviving Spouse/Domestic Partner?

All survivors must also complete an EFT Authorization for deposit to, or withdrawal from, the bank account to be used for billing and reimbursements, by May 15, 2012. Survivors who are not PERS/STRS annuitants must pre-pay quarterly in accordance with current procedures.

Does This EFT Authorization Also Authorize Medicare Part B Reimbursement Deposits?

Yes, this also provides authorization to deposit Medicare reimbursement, if applicable.

What If I Have Questions or Need Assistance?

Secova is available to answer questions, provide information and assist retirees with enrollment processes, completing forms and submission of documents. Secova contact information is included below.

Secova Customer Service

Phone: (866) 364-2594
eFax: (866) 635-4606
E-mail: fhda.retireebenefits@secova.com

Employee/Retiree Monthly Contribution Rates Effective July 1, 2012 – December 31, 2012

2012 **CalPERS PLAN**	**Per Month Contribution**
PERS Care / PERS Care-Medicare	
E	$427
E + 1	$853
E + family	$1,280
PERS Choice / PERS Choice Medicare	
E	$117
E + 1	$233
E + family	$350
PERS Select / PERS Select-Medicare	
E	$65
E + 1	$130
E + family	$195
Blue Shield Access+ / Blue Shield Access+ - Medicare	
E	$240
E + 1	$480
E + family	$720
Blue Shield NetValue / Blue Shield NetValue-Medicare	
E	$162
E + 1	$324
E + family	$486
Kaiser CA / Kaiser CA-Medicare	
E	$70
E + 1	$140
E + family	$210

Foothill-De Anza Community College District
COBRA Monthly Rates for the Period of July - December 2012

Medical Only Monthly Premium	Single	Two Party	Family
Kaiser HMO	$622.65	$1,245.30	$1,618.88
Blue Shield NetValue HMO	$623.82	$1,247.64	$1,621.93
Blue Shield Access+ HMO	$725.32	$1,450.64	$1,885.84
PERS Select	$497.14	$994.28	$1,292.55
PERS Choice	$585.63	$1,731.27	$1,522.65
PERS Care	$1,049.81	$2,099.63	$2,729.52
EAP/Dental/Vision **Monthly Premium**	**Single**	**Two Party**	**Family**
Dental	$72.51	$145.02	$203.02
Vision	$9.84	$19.67	$27.54
EAP	$3.25	$3.25	$3.25
Combined Medical/EAP/ Dental/Vision **Monthly Premium**	**Single**	**Two Party**	**Family**
Kaiser HMO	$708.25	$1,413.24	$1,852.69
Blue Shield NetValue HMO	$709.42	$1,415.58	$1,855.74
Blue Shield Access+ HMO	$810.92	$1,618.58	$2,119.65
PERS Select	$582.74	$1,162.22	$1,526.36
PERS Choice	$671.23	$1,899.21	$1,756.46
PERS Care	$1,135.41	$2,267.57	$2,963.33

4 Annual Health Plan Notices

Legal Disclosures, Notifications

Foothill-De Anza Community College District
HEALTH PLAN NOTICES
2012

TABLE OF CONTENTS

Rev. 3/30/12

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "IMPORTANT NOTICE Medicare Part D Creditable Coverage: Your Prescription Drug Coverage and Medicare."

IMPORTANT NOTICE Medicare Part D Creditable Coverage: Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Foothill-De Anza Community College District and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Foothill-De Anza Community College District has determined that the prescription drug coverage offered by the Foothill-De Anza Community College District Anthem, Kaiser and Blue Shield Plan is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare — General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15th through December 7th. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go 63 continuous days or longer without "creditable" prescription drug coverage (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage with Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Foothill-De Anza Community College District Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Foothill-De Anza Community College District Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Foothill-De Anza Community College District prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

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 Foothill-De Anza Community College District changes. You also may request a copy.

Rev. 03/30/12

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For More Information About Medicare Prescription Drug Coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: March 30, 2012
Name of Entity/Sender: Christine Vo
Contact — Position/Office: Benefits Manager
Address: 12345 El Monte Road, Los Altos Hills, CA 94022
Phone Number: 650) 949-6224

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

Rev. 03/30/12

IMPORTANT NOTICE

HIPAA Comprehensive Notice of Privacy Policy and Procedures

**This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.
Please review it carefully.**

This Notice is provided to you on behalf of:

Foothill-De Anza Community College District Medical Plan

Foothill-De Anza Community College District Dental Care Plan

Foothill-De Anza Community College District Vision Plan

Foothill-De Anza Community College District Flexible Benefits Plan

[If separate plans: These plans comprise what is called an "Affiliated Covered Entity," and are treated as a single plan for purposes of this Notice and the privacy rules that require it. For purposes of this Notice, we'll refer to these plans as a single "Plan."]

The Plan's Duty to Safeguard Your Protected Health Information.
Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Foothill-De Anza Community College District that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

- **Treatment**: Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health care operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

Other Uses and Disclosures of Your PHI Not Requiring Authorization.

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as ABC Company) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and dis-enrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.

- **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research. To avert threat to health or safety: In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Authorization:
For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to Have an Opportunity to Object:
The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information.
You have the following rights relating to your protected health information:

- **To request restrictions on uses and disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

- *Effective February 17, 2010, you can restrict disclosure of PHI for payment or health care operations if you pay the health care provider the full out-of-pocket cost.*

- **To choose how the Plan contacts you:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

A new federal law, the American Reinvestment and Recovery Act of 2009 (ARRA) has made numerous changes to the rules governing PHI that is maintained by the Plan and its service providers (business associates). Effective September 23, 2009, any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or

disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach. The notice will be provided to you if the breach poses a significant risk of financial, reputational or other harm to you.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information or to Submit a Complaint.

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:

Christine Vo
Benefits Manager
650-949-6224

The Plan's Deputy Privacy Official(s) is/are:

Christine Vo
Benefits Manager
650-949-6224

Rev. 03/30/12

Organized Health Care Arrangement Designation

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are:

Foothill-De Anza Community College District Medical Plan

Foothill-De Anza Community College District Dental Care Plan

Foothill-De Anza Community College District Vision Plan

Foothill-De Anza Community College District Flexible Benefits Plan

Effective Date

The effective date of this Notice is: March 30, 2012

Rev. 03/30/12

NOTICE OF PRE-EXISTING CONDITION RESTRICTIONS

The CalPERS Anthem PPO medical plans imposes a preexisting condition exclusion on adults over the age of 18 (individuals under age 19 are not subject to the pre-existing condition restriction, effective the first day of the first plan year beginning on or after September 23, 2010]). This means that if a 19-year-old or older enrollee has a medical condition before coming to the Plan, the enrollee might have to wait a certain period of time before the Plan will provide coverage for that condition.

This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a **six-month period.** Generally, this six-month period ends the day before coverage becomes effective.

However, if the enrollee was in a waiting period for coverage, the six-month period ends on the day before the waiting period begins.

The preexisting condition exclusion does not apply to pregnancy nor to an employee or dependent child under the age of 19 who is enrolled in the plan.

This exclusion may last up to **12 months** (18 months if the enrollee is a late enrollee) from the first day of coverage, or, if the enrollee was in a waiting period, from the first day of the waiting period. However, the enrollee can reduce the length of this exclusion period by the number of days of his or her prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if the enrollee has not experienced a break in coverage of at least 63 days.

To reduce the 12-month (or 18-month) exclusion period by the enrollee's prior creditable coverage, you or the enrollee should give us a copy of any certificates of creditable coverage you or the enrollee have. If you do not have a certificate, but you or the enrollee do have prior health coverage, we will help you or the enrollee obtain one from the enrollee's prior plan or insurance company. There are also other ways that an enrollee may prove prior creditable coverage.

Rev. 03/30/12

Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to:

Anthem Blue Cross
Tel: (877) 737-7776 or 818-24-5141 (outside of U.S)

Rev. 03/30/12

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within **60 days** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within **60 days** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "30 days" after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Christine Vo, Benefits Manager, 650-949-6224

[**Note:** Additional information may be required if the plan requires that persons declining coverage under the plan state, in writing, the reason(s) for declining coverage.]

This notice is relevant for healthcare coverages subject to the HIPAA portability rules.

Rev. 03/30/12

Notice of Right to Designate Primary Care Provider and of No Obligation for Pre-Authorization for Ob/Gyn Care

The CalPERS Kaiser and Blue Shield medical plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, CalPERS Kaiser and Blue Shield plans 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:

Kaiser Permanente
Member Services (800) 464-4000

Blue Shield of California
Member Services (800) 334-5847

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

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

Kaiser Permanente
Member Services (800) 464-4000

Blue Shield of California
Member Services (800) 334-5847

Rev. 03/30/12

Women's Health and Cancer Rights Notice

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

The Anthem, Kaiser and Blue Shield plans provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description/ or contact your Plan Administrator at:

Anthem Blue Cross
Member Services: (877) 737-7776
or 818-24-5141 (outside of U.S)

Blue Shield of California
Member Services (800) 334-5847

Kaiser Permanente
Member Services (800) 464-4000

Rev. 03/30/12

Medicaid and the Children's Health Insurance Program (CHIP) Offer of Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility.

Rev. 03/30/12

List of States Where Premium Assistance May Be Available to You

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://www.medicaid.alabama.gov	Website: http://www.dhcs.ca.gov/services/Pages/
Phone: 1-800-362-1504	TPLRD_CAU_cont.aspx
	Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO – Medicaid and CHIP**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/	Medicaid Website: http://www.colorado.gov/
Phone (Outside of Anchorage): 1-888-318-8890	Medicaid Phone: 1-800-866-3513
Phone (Anchorage): 907-269-6529	CHIP Website: http:// www.CHPplus.org
	CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx	
Phone: 1-877-764-5437	
ARKANSAS – CHIP	**FLORIDA – Medicaid**
Website: http://www.arkidsfirst.com/	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml
Phone: 1-888-474-8275	Phone: 1-866-762-2237
GEORGIA – Medicaid	**MONTANA – Medicaid**
Website: http://dch.georgia.gov/	Website: http://medicaidprovider.hhs.mt.gov/clientpages/ clientindex.shtml
Click on Programs, then Medicaid	Telephone: 1-800-694-3084
Phone: 1-800-869-1150	
IDAHO – Medicaid and CHIP	**NEBRASKA – Medicaid**
Medicaid Website: www.accesstohealthinsurance.idaho.gov	Website: http://www.dhhs.ne.gov/med/medindex.htm
Medicaid Phone: 1-800-926-2588	Phone: 1-877-255-3092
CHIP Website: www.medicaid.idaho.gov	
CHIP Phone: 1-800-926-2588	
INDIANA – Medicaid	**NEVADA – Medicaid and CHIP**
Website: http://www.in.gov/fssa/2408.htm	Medicaid Website: http://dwss.nv.gov/
Phone: 1-877-438-4479	Medicaid Phone: 1-800-992-0900
	CHIP Website: http://www.nevadacheckup.nv.org/
	CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/	
Phone: 1-888-346-9562	

KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: https://www.khpa.ks.gov	Website: http://www.dhhs.state.nh.us/DHHS/
Phone: 800-766-9012	MEDICAIDPROGRAM/default.htm
	Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/ clients/medicaid/
Phone: 1-800-635-2570	Medicaid Phone: 1-800-356-1561
	CHIP Website: http://www.njfamilycare.org/index.html
	CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.la.hipp.dhh.louisiana.gov	
Phone: 1-888-342-6207	
MAINE – Medicaid	**NEW MEXICO – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/oms/	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html
	Phone: 1-800-321-5557
	Medicaid Phone: 1-888-997-2583
	CHIP Website: http://www.hsd.state.nm.us/mad/index.html
	Click on Insure New Mexico
	CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth	
Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK – Medicaid**
Website: http://www.dhs.state.mn.us/	Website: http://www.nyhealth.gov/health_care/medicaid/
Click on Health Care, then Medical Assistance	Phone: 1-800-541-2831
Phone: 800-657-3739	
MISSOURI – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.dss.mo.gov/mhd/index.htm	Website: http://www.nc.gov
Phone: 573-751-6944	Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/	Website: http://health.utah.gov/medicaid/
Phone: 1-800-755-2604	Phone: 1-866-435-7414

OKLAHOMA – Medicaid	**VERMONT– Medicaid**
Website: http://www.insureoklahoma.org	Website: http://ovha.vermont.gov/
Phone: 1-888-365-3742	Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Medicaid & CHIP Website:	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm
http://www.oregonhealthykids.gov	Medicaid Phone: 1-800-432-5924
Medicaid & CHIP Phone: 1-877-314-5678	CHIP Website: http://www.famis.org/
	CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.dpw.state.pa.us/partnersproviders/ medicalassistance/doingbusiness/003670053.htm	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-644-7730	Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	**WEST VIRGINIA – Medicaid**
Website: www.dhs.ri.gov	Website: http://www.wvrecovery.com/hipp.htm
Phone: 401-462-5300	Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN – Medicaid**
Website: http://www.scdhhs.gov	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm
Phone: 1-888-549-0820	Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: https://www.gethipptexas.com/	Website: http://www.health.wyo.gov/healthcarefin/index.html
Phone: 1-800-440-0493	Telephone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

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

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

5 Other Information

Domestic Partner Imputed Income (Active Employees)

Foothill-De Anza Community College District Monthly Imputed Income Rates — 7/1/2012 to 12/31/12		
Domestic Partners (Active Employees)	**Medical/Dental/Vision**	**Medical Only**
PERSCare	**PERSCare Medical/Dental/Vision With EAP, Dep. Life**	**PERSCare Medical Only With EAP, Dep. Life**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$683.96	$603.23
Same-Sex DP Only with Medicare	$87.16	$6.43
Same-Sex Domestic Partner's CHILD ONLY	$683.96	$603.23
Same-Sex DP w/o Medicare, Plus DP Child	$940.82	$795.50
Same-Sex DP w/o Medicare, Plus DP Children	$940.82	$795.50
Same-Sex DP with Medicare, Plus DP Child	$344.02	$198.70
Same-Sex DP with Medicare, Plus DP Children	$344.02	$198.70
Same-Sex Domestic Partner's CHILDREN ONLY	$940.82	$795.50
PERS Choice	**PERS Choice Medical/Dental/Vision With EAP, Dep. Life**	**PERS Choice Medical Only With EAP, Dep. Life**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$538.88	$458.15
Same-Sex DP Only with Medicare	$348.17	$267.44
Same-Sex Domestic Partner's CHILD ONLY	$538.88	$458.15
Same-Sex DP w/o Medicare, Plus DP Child	$832.69	$687.37
Same-Sex DP w/o Medicare, Plus DP Children	$832.69	$687.37
Same-Sex DP with Medicare, Plus DP Child	$641.98	$496.66
Same-Sex DP with Medicare, Plus DP Children	$641.98	$496.66
Same-Sex Domestic Partner's CHILDREN ONLY	$832.69	$687.37
PERS Select	**PERS Select Medical/Dental/Vision With EAP, Dep. Life**	**PERS Select Medical Only With EAP, Dep. Life**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$503.12	$422.39
Same-Sex DP Only with Medicare	$503.12	$422.39
Same-Sex Domestic Partner's CHILD ONLY	$399.17	$318.44
Same-Sex DP w/o Medicare, Plus DP Child	$796.87	$651.55
Same-Sex DP w/o Medicare, Plus DP Children	$796.87	$651.55
Same-Sex DP with Medicare, Plus DP Child	$692.92	$547.60
Same-Sex DP with Medicare, Plus DP Children	$692.92	$547.60
Same-Sex Domestic Partner's CHILDREN ONLY	$796.87	$651.55
The definition of Children includes Certified Disabled Dependents over the age of 26		

Domestic Partner Imputed Income (Active Employees)

Foothill-De Anza Community College District Monthly Imputed Income Rates — 7/1/2012 to 12/31/12		
Domestic Partners (Active Employees)	**Medical/Dental/Vision**	**Medical Only**
Blue Shield Access+	**Blue Shield Access+ Medical/ Dental/Vision With EAP, Dep. Life**	**Blue Shield Access+ Medical Only With EAP, Dep. Life**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$551.83	$471.10
Same-Sex DP Only with Medicare	$178.72	$97.99
Same-Sex Domestic Partner's CHILD ONLY	$551.83	$471.10
Same-Sex DP w/o Medicare, Plus DP Child	$804.81	$659.49
Same-Sex DP w/o Medicare, Plus DP Children	$804.81	$659.49
Same-Sex DP with Medicare, Plus DP Child	$431.70	$286.38
Same-Sex DP with Medicare, Plus DP Children	$431.70	$286.38
Same-Sex Domestic Partner's CHILDREN ONLY	$804.81	$659.49
Blue Shield NetValue	**Blue Shield NetValue Medical/ Dental/Vision With EAP, Dep. Life**	**Blue Shield NetValue Medical Only With EAP, Dep. Life**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$530.32	$449.59
Same-Sex DP Only with Medicare	$256.72	$175.99
Same-Sex Domestic Partner's CHILD ONLY	$530.32	$449.59
Same-Sex DP w/o Medicare, Plus DP Child	$801.59	$656.27
Same-Sex DP w/o Medicare, Plus DP Children	$801.59	$656.27
Same-Sex DP with Medicare, Plus DP Child	$527.99	$382.67
Same-Sex DP with Medicare, Plus DP Children	$527.99	$382.67
Same-Sex Domestic Partner's CHILDREN ONLY	$801.59	$656.27
Kaiser	**Kaiser Medical/Dental/Vision With EAP, Dep. Life**	**Kaiser Medical Only With EAP, Dep. Life**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$621.17	$540.44
Same-Sex DP Only with Medicare	$288.54	$207.81
Same-Sex Domestic Partner's CHILD ONLY	$621.17	$540.44
Same-Sex DP w/o Medicare, Plus DP Child	$983.75	$838.43
Same-Sex DP w/o Medicare, Plus DP Children	$983.75	$838.43
Same-Sex DP with Medicare, Plus DP Child	$651.12	$505.80
Same-Sex DP with Medicare, Plus DP Children	$651.12	$505.80
Same-Sex Domestic Partner's CHILDREN ONLY	$983.75	$838.43
The definition of Children includes Certified Disabled Dependents over the age of 26		

Domestic Partner Imputed Income (Part-time Faculty)

Foothill-De Anza Community College District Monthly Imputed Income Rates - 7/1/2012 to 12/31/12		
Domestic Partners (Part Time Faculty — Medical Only)	**Load: .50 to .67**	**Load: .40 to .499**
PERSCare	**PERSCare Medical Only Load: .50 to .67**	**PERSCare Medical Only Load: .40 to .499**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$331.23	$244.23
Same-Sex DP Only with Medicare	$0.00	$0.00
Same-Sex Domestic Partner's CHILD ONLY	$331.23	$244.23
Same-Sex DP w/o Medicare, Plus DP Child	$530.77	$390.77
Same-Sex DP w/o Medicare, Plus DP Children	$530.77	$390.77
Same-Sex DP with Medicare, Plus DP Child	$0.00	$0.00
Same-Sex DP with Medicare, Plus DP Children	$0.00	$0.00
Same-Sex Domestic Partner's CHILDREN ONLY	$530.77	$390.77
PERS Choice	**PERS Choice Medical Only Load: .50 to .67**	**PERS Choice Medical Only Load: .40 to .499**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$332.15	$243.15
Same-Sex DP Only with Medicare	$141.44	$52.44
Same-Sex Domestic Partner's CHILD ONLY	$332.15	$243.15
Same-Sex DP w/o Medicare, Plus DP Child	$530.64	$389.64
Same-Sex DP w/o Medicare, Plus DP Children	$530.64	$389.64
Same-Sex DP with Medicare, Plus DP Child	$339.93	$198.93
Same-Sex DP with Medicare, Plus DP Children	$339.93	$198.93
Same-Sex Domestic Partner's CHILDREN ONLY	$530.64	$389.64
PERS Select	**PERS Select Medical Only Load: .50 to .67**	**PERS Select Medical Only Load: .40 to .499**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$331.39	$244.39
Same-Sex DP Only with Medicare	$331.39	$244.39
Same-Sex Domestic Partner's CHILD ONLY	$227.44	$140.44
Same-Sex DP w/o Medicare, Plus DP Child	$529.82	$389.82
Same-Sex DP w/o Medicare, Plus DP Children	$529.82	$389.82
Same-Sex DP with Medicare, Plus DP Child	$425.87	$285.87
Same-Sex DP with Medicare, Plus DP Children	$425.87	$285.87
Same-Sex Domestic Partner's CHILDREN ONLY	$529.82	$389.82
Notes: The definition of Children includes Certified Disabled Dependents over the age of 26		

Domestic Partner Imputed Income (Part-time Faculty)

Foothill-De Anza Community College District Monthly Imputed Income Rates - 7/1/2012 to 12/31/12		
Domestic Partners (Part-time Faculty — Medical Only)	**Load: .50 to .67**	**Load: .40 to .4999**
Blue Shield Access+	**Blue Shield Access+ Medical Only Load: .50 to .67**	**Blue Shield Access+ Medical Only Load: .40 to .499**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$332.10	$243.10
Same-Sex DP Only with Medicare	$0.00	$0.00
Same-Sex Domestic Partner's CHILD ONLY	$332.10	$243.10
Same-Sex DP w/o Medicare, Plus DP Child	$530.76	$389.76
Same-Sex DP w/o Medicare, Plus DP Children	$530.76	$389.76
Same-Sex DP with Medicare, Plus DP Child	$157.65	$16.65
Same-Sex DP with Medicare, Plus DP Children	$157.65	$16.65
Same-Sex Domestic Partner's CHILDREN ONLY	$530.76	$389.76
Blue Shield NetValue	**Blue Shield NetValue Medical Only Load: .50 to .67**	**Blue Shield NetValue Medical Only Load: .40 to .499**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$331.59	$243.59
Same-Sex DP Only with Medicare	$57.99	$0.00
Same-Sex Domestic Partner's CHILD ONLY	$331.59	$243.59
Same-Sex DP w/o Medicare, Plus DP Child	$530.54	$389.54
Same-Sex DP w/o Medicare, Plus DP Children	$530.54	$389.54
Same-Sex DP with Medicare, Plus DP Child	$256.94	$115.94
Same-Sex DP with Medicare, Plus DP Children	$256.94	$115.94
Same-Sex Domestic Partner's CHILDREN ONLY	$530.54	$389.54
Kaiser	**Kaiser Medical Only Load: .50 to .67**	**Kaiser Medical Only Load: .40 to .499**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$414.44	$305.44
Same-Sex DP Only with Medicare	$81.81	$0.00
Same-Sex Domestic Partner's CHILD ONLY	$414.44	$305.44
Same-Sex DP w/o Medicare, Plus DP Child	$663.70	$487.70
Same-Sex DP w/o Medicare, Plus DP Children	$663.70	$487.70
Same-Sex DP with Medicare, Plus DP Child	$331.07	$155.07
Same-Sex DP with Medicare, Plus DP Children	$331.07	$155.07
Same-Sex Domestic Partner's CHILDREN ONLY	$663.70	$487.70
Notes: The definition of Children includes Certified Disabled Dependents over the age of 26		

Domestic Partner Imputed Income (Retirees Without Medicare & With Medicare)

Foothill-De Anza Community College District Monthly Imputed Income Rates - 7/1/2012 to 12/31/12 Domestic Partners (Retirees With and Without Medicare Retiree Medical/Dental/Vision)		
	Retiree Without Medicare	**Retiree With Medicare**
PERSCare	**PERSCare Medical/Dental/Vision Retiree Without Medicare**	**PERSCare Medical/Dental/Vision Retiree With Medicare**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$683.96	$683.96
Same-Sex DP Only with Medicare	$87.16	$87.16
Same-Sex Domestic Partner's CHILD ONLY	$683.96	$683.96
Same-Sex DP w/o Medicare, Plus DP Child	$874.50	$874.50
Same-Sex DP w/o Medicare, Plus DP Children	$874.50	$874.50
Same-Sex DP with Medicare, Plus DP Child	$342.29	$342.29
Same-Sex DP with Medicare, Plus DP Children	$342.29	$342.29
Same-Sex Domestic Partner's CHILDREN ONLY	$939.09	$939.09
PERS Choice	**PERS Choice Medical/Dental/Vision Retiree Without Medicare**	**PERS Choice Medical/Dental/Vision Retiree With Medicare**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$538.88	$538.88
Same-Sex DP Only with Medicare	$348.17	$348.17
Same-Sex Domestic Partner's CHILD ONLY	$538.88	$538.88
Same-Sex DP w/o Medicare, Plus DP Child	$766.37	$766.37
Same-Sex DP w/o Medicare, Plus DP Children	$766.37	$766.37
Same-Sex DP with Medicare, Plus DP Child	$766.37	$640.25
Same-Sex DP with Medicare, Plus DP Children	$766.37	$640.25
Same-Sex Domestic Partner's CHILDREN ONLY	$830.96	$830.96
PERS Select	**PERS Select Medical/Dental/Vision Retiree Without Medicare**	**PERS Select Medical/Dental/Vision Retiree With Medicare**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$503.12	$503.12
Same-Sex DP Only with Medicare	$399.17	$399.17
Same-Sex Domestic Partner's CHILD ONLY	$503.12	$503.12
Same-Sex DP w/o Medicare, Plus DP Child	$730.55	$730.55
Same-Sex DP w/o Medicare, Plus DP Children	$730.55	$730.55
Same-Sex DP with Medicare, Plus DP Child	$730.55	$691.19
Same-Sex DP with Medicare, Plus DP Children	$730.55	$691.19
Same-Sex Domestic Partner's CHILDREN ONLY	$795.14	$795.14
The definition of Children includes Certified Disabled Dependents over the age of 26		

Domestic Partner Imputed Income (Retirees Without Medicare & With Medicare)

Foothill-De Anza Community College District Monthly Imputed Income Rates - 7/1/2012 to 12/31/12 Domestic Partners (Retirees With and Without Medicare Retiree Medical/Dental/Vision)		
	Retiree Without Medicare	**Retiree With Medicare**
Blue Shield Access+	**Blue Shield Access+ Medical/Dental/ Vision Retiree Without Medicare**	**Blue Shield Access+ Medical/Dental/Vision Retiree With Medicare**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$551.83	$551.83
Same-Sex DP Only with Medicare	$178.72	$178.72
Same-Sex Domestic Partner's CHILD ONLY	$551.83	$551.83
Same-Sex DP w/o Medicare, Plus DP Child	$738.49	$738.49
Same-Sex DP w/o Medicare, Plus DP Children	$738.49	$738.49
Same-Sex DP with Medicare, Plus DP Child	$738.49	$429.97
Same-Sex DP with Medicare, Plus DP Children	$738.49	$429.97
Same-Sex Domestic Partner's CHILDREN ONLY	$803.08	$803.08
Blue Shield NetValue	**Blue Shield NetValue Medical/Dental/ Vision Retiree Without Medicare**	**Blue Shield NetValue Medical/Dental/Vision Retiree With Medicare**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$530.32	$530.32
Same-Sex DP Only with Medicare	$256.72	$256.72
Same-Sex Domestic Partner's CHILD ONLY	$530.32	$530.32
Same-Sex DP w/o Medicare, Plus DP Child	$735.27	$735.27
Same-Sex DP w/o Medicare, Plus DP Children	$735.27	$735.27
Same-Sex DP with Medicare, Plus DP Child	$735.27	$526.26
Same-Sex DP with Medicare, Plus DP Children	$735.27	$526.26
Same-Sex Domestic Partner's CHILDREN ONLY	$799.86	$799.86
Kaiser	**Kaiser Medical/Dental/Vision Retiree Without Medicare**	**Kaiser Medical/Dental/Vision Retiree With Medicare**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$621.17	$621.17
Same-Sex DP Only with Medicare	$288.54	$288.54
Same-Sex Domestic Partner's CHILD ONLY	$621.17	$621.17
Same-Sex DP w/o Medicare, Plus DP Child	$917.43	$917.43
Same-Sex DP w/o Medicare, Plus DP Children	$917.43	$917.43
Same-Sex DP with Medicare, Plus DP Child	$917.43	$649.39
Same-Sex DP with Medicare, Plus DP Children	$917.43	$649.39
Same-Sex Domestic Partner's CHILDREN ONLY	$982.02	$982.02
The definition of Children includes Certified Disabled Dependents over the age of 26		

Foothill De Anza Community College District JULY 1, 2010 SUMMARY PLAN COMPARISONS			
Plan Provisions	EPO	PersCare	
Plan	In Network	In Network	Out of Network
Plan Type	In Network Only	Open Access PPO	
Deductible (Calendar Year)	$350/ person	$500/ person	
	$1,050/family	$1,000/family	
Deductible Apply to OOP max?	No	No	No maximum
Out of Pocket Maximum	$1,000/person	$2,000/person	No maximum
	$3,000/family	$4,000/family	No maximum
Lifetime Maximum	No maximum	No maximum	No maximum
Office Visits - Primary Care	$25 copay	$20 copay	40% after Deductible
Office Visits - Specialists	$30 copay	$20 copay	40% after Deductible
Coinsurance You Pay	10%	10%	40%
Hospital Copay	$100 copay per confinement	$250 Deductible per confinement	
Hospital Coinsurance	10% after Deductible	10% after Deductible	40% after Deductible
Outpatient Services	10% after Deductible	10% after Deductible	40% after Deductible
Surgery/Anesthesia	10% after Deductible	10% after Deductible	40% after Deductible
Preventative Care	$0	$0	40% after Deductible
Allergy Testing/Treatment	$30 copay	10% after Deductible	40% after Deductible
Diagnostic X-ray and Lab	10% after Deductible	10% after Deductible	40% after Deductible
DXL with Physician OV	$25 copay	10% after Deductible	40% after Deductible
Chiropractic Care	$25 copay	10% after Deductible	40% after Deductible
Chiropractic Maximum	30 Combined Chiro/Acupuncture Visits Per Year	20 Combined Chiro/Acupuncture Visits Per Year	
Acupuncture Care	$25 copay, pain therapy and nausea only	10% after Deductible	40% after Deductible

3/28/2012

CalPERS PPO Plans 2012 Benefits			
PersChoice		PersSelect (Sutter Excluded)	
In Network	Out of Network	In Network	Out of Network
Open Access PPO		Select Network PPO	
$500/ person		$500/ person	
$1,000/family		$1,000/family	
No	No maximum	No	No maximum
$3,000/person	No maximum	$3,000/person	No maximum
$6,000/family	No maximum	$6,000/family	No maximum
No maximum	No maximum	No maximum	No maximum
$20 copay	40% after Deductible	$20 copay	40% after Deductible
$20 copay	40% after Deductible	$20 copay	40% after Deductible
20%	40%	20%	40%
$0 copay per confinement		$0 copay per confinement	
20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
$0	40% after Deductible	$0	40% after Deductible
20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
15 Combined Chiro/Acupuncture Visits Per Year		15 Combined Chiro/Acupuncture Visits Per Year	
20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible

Foothill De Anza Community College District JULY 1, 2010 SUMMARY PLAN COMPARISONS			
Plan Provisions	EPO	PersCare	
Plan	In Network	In Network	Out of Network
Plan Type	In Network Only	Open Access PPO	
Acupuncture Maximum	30 Combined Chiro/Acupuncture Visits Per Year	20 Combined Chiro/Acupuncture Visits Per Year	
Urgent Care	$30 Copay	$20 Copay	40% after Deductible
Emergency Room	$100 Deductible (waived if admitted)	$50 ER Deductible (waived if admitted)	
Emergency Room Services	10%	10%	
If Emergency Criteria Not Met	$100 Deductible (waived if admitted)	10% after Deductible - ER facility charge not covered	40% after Deductible - ER facility charge not covered
Mental Health			
Inpatient	$100 Copay, 10% after Deductible	$250 Deductible, then 10%	40% after Deductible
Outpatient	$25 Copay	10% after Deductible	40% after Deductible
Substance Abuse			
Inpatient	$100 Copay, 10% after Deductible	$250 Deductible, then 10%	40% after Deductible
Outpatient	$25 Copay	10% after Deductible	40% after Deductible
Ambulance	10% after Deductible	20% after Deductible	
Home Health Care	10% after Deductible	10% after Deductible	40% after Deductible
Home Health Care Visit Limit	60 per calendar year	100 visit per calendar year	
Hospice	10% after Deductible	10% after Deductible	
Hospice Care Lifetime Limit	$10,000	No limit	
Occupational/Physical/Speech Therapy			
Inpatient	$100 Copay, 10% after Deductible	No Charge	
Outpatient	$30 Copay	20% after Deductible	
Precertification Req.		No precert required	
Skilled Nursing Care			

CalPERS PPO Plans 2012 Benefits			
PersChoice		PersSelect (Sutter Excluded)	
In Network	Out of Network	In Network	Out of Network
Open Access PPO		Select Network PPO	
15 Combined Chiro/Acupuncture Visits Per Year		15 Combined Chiro/Acupuncture Visits Per Year	
$20 Copay	40% after Deductible	$20 Copay	40% after Deductible
$50 ER Deductible (waived if admitted)		$50 ER Deductible (waived if admitted)	
20%		20%	
20% after Deductible - ER facility charge not covered	40% after Deductible - ER facility charge not covered	20% after Deductible - ER facility charge not covered	40% after Deductible - ER facility charge not covered
20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
20% after Deductible		20% after Deductible	
20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
45 visits per calendar year		45 visits per calendar year	
20% after Deductible		20% after Deductible	
No limit		No limit	
No Charge		No Charge	
20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
> 24 Visits		> 24 Visits	

Foothill De Anza Community College District JULY 1, 2010 SUMMARY PLAN COMPARISONS			
Plan Provisions	EPO	PersCare	
Plan	In Network	In Network	Out of Network
Plan Type	In Network Only	Open Access PPO	
Inpatient	$100 Copay, 10% after Deductible	10% 1st 10 days, 20% next 170 days, precert req, 180 days max per year	40%, precert req, 180 days max per year
Outpatient	Not covered	Not covered	
Vision Exam	Not covered	Not covered	
Hearing Exam	$25 Copay	10% after Deductible	40% after Deductible
Hearing Aids	50% after Deductible, $5,000 annual max	10% after Deductible	40% after Deductible
Hearing Aid Frequency	one device every 36 months	one device every 36 months	
Durable Medical Equipment	10% after Deductible	10% after Deductible	40% after Deductible
DME Precertification	None	> $1,000	
Prosthetic Device Limit	$10,000	No limit	
Infertility Services	10% after Deductible	Not covered	
Prescription Drug			
Retail			
Generic	$10 Copay/30 days	$5 Copay/30 days	
Brand Formulary	$25 Copay/30 days	$20 Copay/30 days	
Brand Non-Formulary	$50 Copay/30 days	$50 Copay/30 days	
Retail Maintenance			
Generic	$10 Copay/30 days	$10 Copay/30 days	
Brand Formulary	$25 Copay/30 days	$40 Copay/30 days	
Brand Non-Formulary	$50 Copay/30 days	$50 Copay/30 days	
Mail Order			
Generic	$20 Copay/90 days	$10 Copay/90 days	Not Available
Brand	$50 Copay/90 days	$40 Copay/90 days	Not Available
Brand Non-Formulary	$100 Copay/90 days	$50 Copay/90 days	Not Available
Rx Copy Maximum/person	$1,000/year	$1,000/year	

This document is intended to merely highlight or summarize certain aspects of the employer's benefit program(s). It is not a summary p
plan documents. All statements in this summary are subject to the terms of the official plan documents, as interpreted by the appropriat
documents, the terms of the plan documents control. The employer reserves the right to review, change, or terminate the plan, or any b

CalPERS PPO Plans 2012 Benefits			
PersChoice		PersSelect (Sutter Excluded)	
In Network	Out of Network	In Network	Out of Network
Open Access PPO		Select Network PPO	
20% 1st 10 days, 30% next 90 days, precert req, 100 days max per year	40%, precert req, 100 days max per year	20% 1st 10 days, 30% next 90 days, precert req, 100 days max per year	40%, precert req, 100 days max per year
Not covered		Not covered	
Not covered		Not covered	
20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
one device every 36 months		one device every 36 months	
20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
> $1,000		> $1,000	
No limit		No limit	
Not covered		Not covered	
$5 Copay/30 days		$5 Copay/30 days	
$20 Copay/30 days		$20 Copay/30 days	
$50 Copay/30 days		$50 Copay/30 days	
$10 Copay/30 days		$10 Copay/30 days	
$40 Copay/30 days		$40 Copay/30 days	
$100 Copay/30 days		$100 Copay/30 days	
$10 Copay/90 days	Not Available	$10 Copay/90 days	Not Available
$40 Copay/90 days	Not Available	$40 Copay/90 days	Not Available
$100 Copay/90 days	Not Available	$100 Copay/90 days	Not Available
$1,000/year		$1,000/year	

plan description (SPD) or an official plan document. Your rights and obligations under the program(s) are set forth in the official
e plan fiduciary. In the case of an ambiguity or outright conflict between a provision in this summary and a provision in the plan
enefits under it, for any reason, at any time and without advance notice to any person.

Foothill De Anza Community College District JULY 1, 2010 SUMMARY PLAN COMPARISONS		CalPERS HMO Plans 2012 Benefits		
Plan Provisions	Kaiser	Kaiser	Blue Shield Access+	Blue Shield Net Value
Plan	In Network	In Network	In Network	In Network
Plan Type	HMO	HMO	HMO	HMO
Deductible (Calendar Year)	$0/person	$0/person	$0/person	$0/person
	$0/family	$0/family	$0/family	$0/family
Out of Pocket Maximum	$1,500/person	$1,500/person	$1,500/person	$1,500/person
	$3,000/family	$3,000/family	$3,000/family	$3,000/family
Lifetime Maximum Limit	No Limit	No Limit	No Limit	No Limit
Office Visits - Primary Care	$20 copay	$15 copay	$15 copay	$15 copay
Office Visits - Specialists	$20 copay	$30 copay	$30 copay	$30 copay
Specialist Refferal Required?	Yes	Yes	No, if in same physician med group	No, if in same physician med group
Coinsurance You Pay	0%	0%	0%	0%
Hospital Copay	No Charge	No Charge	No Charge	
Outpatient Services	$20 Per Procedure	$15 Per Procedure	$0 - ($250 copay for specified procedures)	
Surgery/Anesthesia	$20 Outpatient	$15 Outpatient	No Charge	
Preventative Care	$0	$0	$0	$0
Allergy Testing/Treatment	No Charge	$15 testing	No Charge	
Diagnostic X-ray and Lab	Some Copays	Some Copays	No Charge	
DXL with Physician OV	$0	$0	$0	$0
Chiropractic Care	$15 copay	Not Covered	Not Covered	
Chiropractic Maximum	30 Visits Per Year	Not Covered	Not Covered	
Acupuncture Care	$20 copay when med necessary	$15 copay when med necessary	Not Covered	
Acupuncture Maximum	None	None	Not Covered	
Urgent Care	$20 Copay	$15 copay	$15 copay	$15 copay
Emergency Room	$50 Copay(waived if admitted)	$50 Copay(waived if admitted)	$50 Copay(waived if admitted)	$50 Copay(waived if admitted)
Emergency Room Services	100%	100%	100%	100%
If Emergency Criteria Not Met	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Mental Health				
Inpatient	No Charge	No Charge	No Charge	
Outpatient	Individ. - $20 copay, Group - $10 copay	$15 copay	$15 copay	$15 copay
Substance Abuse				
Inpatient	No Charge	No Charge	No Charge	
Outpatient	Individ. - $20 copay, Group - $5 copay	$15 copay	$15 copay	$15 copay
Ambulance	No Charge	No Charge	No Charge	
Home Health Care	No Charge	No Charge	No Charge	
Home Health Care Visit Limit	No Limit	No Limit	No Limit	No Limit
Hospice	No Charge	No Charge	No Charge	
Hospice Care Lifetime Limit	No Limit	No Limit	No Limit	No Limit
Occupational/Physical/Speech Therapy				
Inpatient	No Charge	No Charge	No Charge	

Foothill De Anza Community College District JULY 1, 2010 SUMMARY PLAN COMPARISONS		CalPERS HMO Plans 2012 Benefits		
Plan Provisions	Kaiser	Kaiser	Blue Shield Access+	Blue Shield Net Value
Plan	In Network	In Network	In Network	In Network
Plan Type	HMO	HMO	HMO	HMO
Outpatient	$20 Copay	$15 copay	$15 copay	$15 copay
Precertification Req.	Not Required	Not Required	Not Required	Not Required
Skilled Nursing Care				
Inpatient	No Charge - Up to 100 days	No Charge - Up to 100 days	No Charge - Up to 100 days	
Outpatient	Not Covered	Not Covered	Not Covered	
Vision Exam	No Charge	No Charge	No Charge	
Hearing Exam	No Charge	No Charge	No Charge	
Hearing Aids	$500	$1,000	First $1,000 covered	
Hearing Aid Frequency	Every 36 months	Every 36 months	Every 36 months	Every 36 months
Durable Medical Equipment	No Charge	No Charge	No Charge	
DME Precertification	Not Required	Not Required	Not Required	Not Required
Prosthetic Device Limit	No Limit	No Limit	No Limit	No Limit
Infertility Services	Services for diagnosis and treatment of involuntary infertility and artificial insemination only, no outpatient Rx	50% of allowed charges	50% of allowable amount	
Prescription Drug				
Retail				
Generic	$5 Copay/30 days	$5 Copay/30 days	$5 Copay/30 days	$5 Copay/30 days
Brand Formulary	$10 Copay/30 days	$20 Copay/30 days	$20 Copay/30 days	$20 Copay/30 days
Brand Non-Formulary	N/A	N/A	$50 Copay/30 days - $30 copay specialty Rx	
Retail Maintenance			Generic substitution penalties apply ($5 plus cost difference)	
Generic	$5 Copay/30 days	$5 Copay/30 days	$10 Copay/30 days	$10 Copay/30 days
Brand Formulary	$10 Copay/30 days	$20 Copay/30 days	$40 Copay/30 days	$40 Copay/30 days
Brand Non-Formulary	N/A	N/A	$100 Copay/30 days	$100 Copay/30 days
Mail Order				
Generic	$10 Copay/100 days	$10 Copay/100 days	$10 Copay/100 days	$10 Copay/100 days
Brand	$20 Copay/100 days	$40 Copay/100 days	$40 Copay/100 days	$40 Copay/100 days
Brand Non-Formulary	N/A	N/A	$100 Copay/100 days	$100 Copay/100 days
Rx Copay Maximum/person	No max	No max	$1,000 per person	$1,000 per person
Out-of-Plan Coverage	Emergency Only	Emergency Only	Blue Card	Blue Card

This document is intended to merely highlight or summarize certain aspects of the employer's benefit program(s). It is not a summary plan description (SPD) or an official plan document. Your rights and obligations under the program(s) are set forth in the official plan documents. All statements in this summary are subject to the terms of the official plan documents, as interpreted by the appropriate plan fiduciary. In the case of an ambiguity or outright conflict between a provision in this summary and a provision in the plan documents, the terms of the plan documents control. The employer reserves the right to review, change, or terminate the plan, or any benefits under it, for any reason, at any time and without advance notice to any person.

6 Additional Forms and Documents

Health Benefit Enrollment — Retirees

Affidavit of Marriage/Domestic Partnership (CalPERS)

Affidavit of Domestic Partnership (FHDA)

Affidavit of Parent-Child Relationship

Certificate of Medicare Status

Cobra Election — Actives

Cobra Election — Retirees

CalPERS Change of Address

CalPERS Power of Attorney

CVS Caremark Rx Guide

CVS Caremark Rx Mail Order

Medical Report — Disabled Dependent

Questionnaire — Disabled Dependent

Change of Address — FHDA Employees

Change of Address — Retirees

CalPERS HEALTH BENEFITS RETIREE ENROLLMENT FORM

PA

TO ENROLL, COMPLETE AND RETURN THIS FORM TO:
Health Account Services
P.O. Box 942714, Sacramento, CA 94229-2714
OR SUBMIT BY FAX: (916) 795-1313

(888) CalPERS (or 888-225-7377) | TTY: (916) 795-3240
www.calpers.ca.gov

Member SSN
_____ - _____ - _____

Agency Code and Name:	**Group/Bargaining Unit:**	**Retirement System:** Non-PERS

Name of Retiree/Member:
First Middle Last

Mailing Address:
Number & Street _____
_____
City, State, Zip _____

Sex: ❑ Male ❑ Female
Married: ❑ Yes ❑ No
Date of Birth: __/__/__

Please select your enrollment effective date:
❑ _____ ❑ _____ ❑ _____

Name of CalPERS Health Plan Selection: **Primary Care Physician/Medical Group:**

All persons to be enrolled in the health plan:

Name	Social Security No.	Date of Birth	Relationship	Type of Coverage*
_____	___-__-___	__/__/__	SELF	❑ Basic ❑ Medicare
_____	___-__-___	__/__/__	_____	❑ Basic ❑ Medicare
_____	___-__-___	__/__/__	_____	❑ Basic ❑ Medicare
_____	___-__-___	__/__/__	_____	❑ Basic ❑ Medicare

*NOTE: To enroll in a CalPERS Medicare-coordinated health plan, persons must be enrolled in Medicare Part A and Part B. **A copy of a Medicare card and/or *Certification of Medicare Status* form must be provided for every Medicare-eligible person. Please submit with this enrollment form.**

- ❑ Enclosed is a copy of my Medicare card or *Certification of Medicare* Status form.
- ❑ I am not eligible for Medicare. Attached is evidence of this fact.
- ❑ Enclosed is a copy of my dependent's Medicare card or *Certification of Medicare Status* form.
- ❑ My dependent is not eligible for Medicare. Attached is evidence of this fact.

❑ **I DO NOT WISH** TO ENROLL IN A PLAN UNDER THE ACT
❑ **I ELECT TO ENROLL** IN A HEALTH BENEFITS PLAN AS SHOWN ABOVE AND WILL REMIT MY SHARE OF THE COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE DIRECTLY TO MY FORMER EMPLOYER

Signature	**Date**	**Daytime Phone Number**

Put your name and Social Security number at the top of every page.

Your Name | Social Security Number

Section 5 Retiree's Signature

Please be sure to sign this form.

By signing this form, I elect to change to the plan indicated above and/or add eligible family members. I also certify that the health information listed above is true and complete and authorize deductions, if applicable, to be made from my retirement allowance to cover my share of the health plan premium.

Signature of Retiree | Date

Section 6 Additional Information

You can submit your health plan changes by mail, by phone, or by fax.

After making changes to your health plan, be sure to examine your retirement check to verify that the proper deduction was made. If the deduction is incorrect, call CalPERS to report the discrepancy.

Health Benefits Plan Enrollment for Retirees

Use this form to enroll in a health plan, change your plan, or add an eligible dependent(s) to your plan. All changes are subject to verification of eligibility. You are eligible to enroll in a CalPERS health plan if you meet all of the following requirements:

- Are eligible for enrollment on the date of separation
- Retired within 120 days from the day you separated from your job
- Are receiving a retirement check

Contact CalPERS with any eligibility questions.

Notes

- Any health plan changes made during Open Enrollment become effective the following January 1.
- You can use this form to make changes to your health plan outside of Open Enrollment due to a qualifying life event, such as adding a new spouse, registered domestic partner, or economically dependent child.
  - Adding a spouse requires a copy of your marriage license.
  - Adding a registered domestic partner requires a copy of the approved *Declaration of Domestic Partnership.*
  - Adding a child where a parent-child relationship exists requires an Affidavit of Parent-Child Relationship form (HBD-40).
- Be sure to report changes to CalPERS in a timely manner to avoid retroactive reimbursement liability.
- If you are enrolled in a Medicare Managed Care plan (Medicare Advantage) and are switching to a Supplement to Medicare plan, you must contact your current health plan or the nearest Social Security Administration office to disenroll your Medicare benefits from your current Medicare Managed Care plan. If you do not disenroll, Medicare will not pay for services you receive under your new health plan.
- If any one of your dependents is enrolled in Medicare, please send a copy of the Medicare card.

Mail to: **CalPERS Office of Employer & Member Health Services** • P.O. Box 942714, Sacramento, California 94229-2714

Office of Employer and Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
888 CalPERS (or **888**-225-7377)
TDD - (916)795-3240; FAX (916)795-1313

AFFIDAVIT OF MARRIAGE/DOMESTIC PARTNERSHIP

I, _____ am unable to secure a copy of my **Marriage/Domestic**
(Print Name)

Partnership Certificate. To receive health benefit coverage for my spouse/domestic partner through the Public Employees' Medical and Hospital Care Act Program, I certify that on the

_____ day of _____ , in the year _____,
(Day of Month) (Month) Year (YYYY)

in the state (or Country if ouside the U.S.) of _____,

that I, _____ ,
(Print Name)

was legally and ceremonially married to/formed a domestic partnership with

_____.
(Spouse/Domestic Partner's Name)

I acknowledge this affidavit is a legally binding document. By signing this document below, I agree, pursuant to Goverment Code section 22818(a)(3), that I may be required to reimburse my employer, the health benefit plan, and/or CalPERS for any expenditures made for medical claims, processing fees, administrative expenses, and attorney's fees on behalf of the person I claim as my spouse/domestic partner, if any information submitted in this document is found to be inaccurate or fraudulent. I further agree to notify my Personnel Office or CalPERS immediately of any changes pertaining to marital/domestic partnership status. **Some domestic partners may not be eligible for CalPERS Health Benefits. If you are applying for health benefits on the basis of domestic partnership, contact the California Secretary of State's office to determine whether you are eligible for domestic partnership with the State of California. Some exceptions may be made in the case of contracting agencies that defined and adopted domestic partnership criteria prior to January 1, 2000.**

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____
Date (mm/dd/yyyy) Employee/Annuitant Signature

ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California, County of _____

On _____ before me, _____,
Date (mm/dd/yyyy) Name of Notary

personally appeared _____, personally known to me or (proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

Witness my hand and official seal. **Notary Seal**

_____ | _____ | _____
Signature of Notary Position Title Date (mm/dd/yyyy)

_____
Print Name

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT
Department of Human Resources

AFFIDAVIT FOR ENROLLMENT OF DOMESTIC PARTNERS

I, _____,
(print name of employee)

and

I, _____,
(print name of non-employee domestic partner)

certify that:

1. We are domestic partners of one another within the following definitions:

DEFINITIONS:

Domestic Partnership. Domestic partners are two persons, each aged 18 or older, who have chosen to live together in a committed relationship, who are not legally allowed to marry in the state in which they reside, and who have agreed to be jointly responsible for living expenses incurred during the domestic partnership.

- Live Together. "Live together" means that two people share the same living quarters. Each partner must have the legal right, documented in writing, to possess the living quarters.
- Living Expenses. "Responsible for living expenses" means that the partners are jointly responsible for the common welfare and financial obligations of each other which are incurred during the domestic partnership.

2. Each of us understands that in addition to meeting the definition of domestic partnership provided in Section I above, we must satisfy the additional eligibility criteria provided herein.
3. We are both eighteen (18) years of age or older and are mentally competent to consent to contract.
4. We are each other's sole domestic partner.
5. Neither of us is married.
6. Neither of us has been a member of another domestic partnership within the previous six months, unless that domestic partnership terminated by death.
7. Neither of us is related to the other by blood as would prevent us from marrying under California law (i.e., parent, child, sibling, half-sibling, grandparent, grandchild, niece, nephew, aunt, uncle).

8. We share the same principal place of residence and we intend to do so indefinitely. Currently the address of our principal place of residence is:

   _____

   _____

   _____

9. By signing this Affidavit for enrollment of a Domestic Partner for District benefits, we agree that we both are jointly responsible for the common welfare and financial obligations of each other which are incurred during the domestic partnership. We understand that our practice need not be to contribute equally to the cost of our living expenses but we agree that both of us are responsible for the total cost.

10. Each of us intends that the circumstances which render us eligible for enrollment will remain so indefinitely.

11. Each of us understands and agrees that the employee domestic partner may make health plan and other benefits elections on behalf of the non-employee domestic partner.

12. Each of us understands and agrees that the District may in its discretion, require supportive documentation satisfactory to the District concerning the eligibility criteria and assertions herein. Such documentation may include but not be limited to: a deed showing joint ownership of property, a lease stating both partners' names as lessees, a joint bank account, or other similar documentation.

13. Each of us understands that, in addition to the eligibility requirements of the District for domestic partner coverage, there are terms and conditions and limitations of coverage and eligibility criteria set forth in the offered benefit plans themselves. We understand that we are also bound by the terms of these policies and agreements.

14. Each of us understands that under applicable federal and state tax law, District-provided benefits coverage of the non-employee domestic partner could result in imputed taxable income to the employee, subject to income tax withholding and applicable payroll taxes.

15. Each of us agrees that if there is any change of circumstances attested to in this affidavit, we will, within thirty (30) days of such change of circumstances, file an amendment of this affidavit. The non-employee domestic partner agrees that the employee domestic partner may terminate the domestic partner benefits unilaterally, at any time, irrespective of the view of the non-employee. If the employee-domestic partner executes such an option, the employee shall notify the non-employee domestic partner as soon as possible that his or her benefits have been terminated and it shall be the sole responsibility of that employee to make such notification.

16. Each of us understands that if either of us has made a false statement regarding his or her qualifications as a domestic partner or has failed to comply with the terms of the Affidavit, the District shall have the absolute right to terminate any and all of the domestic partner's benefits in accordance with the eligibility procedures specified in the health benefits plan. Additionally, if the District suffers any loss thereby, the District may bring a civil action against either or both of the domestic partners to recover its losses, including reasonable attorneys' fees and court costs.

17. Each of us understands and agrees that the District Administrator of any benefit plan at issue shall be the sole judge of determining whether we qualify as domestic partners.

18. Each of us declares under penalty of perjury under the laws of the State of California that the assertions in this Affidavit are true and correct.

_____ _____
Signature of Employee Date of Birth

_____ _____
Signature of Non-Employee Domestic Partner Date of Birth

State of California)
) ss.
County of Santa Clara)

On this _____ day of_____,
in the year 20_____, before me,_____,
a Notary Public, State of California, duly commissioned and sworn, personally appeared _____ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) _____ subscribed to the within instrument and acknowledged to me that _____he____ executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

_____
NOTARY PUBLIC, STATE OF CALIFORNIA
My commission expires:_____

BACK TO TOP OF PAGE

Affidavit of Parent-Child Relationship

California Code of Regulations section 599.500(o)

The Public Employees' Medical and Hospital Care Act (PEMHCA), allows employees and annuitants to enroll family members in a CalPERS-sponsored health plan. Pursuant to Title 2, California Code of Regulations (CCR), section 599.500(o), an employee or annuitant may enroll a child, other than an adopted, step or recognized natural child, in the health plan if the employee or annuitant has assumed a "parent-child relationship" with that child in lieu of the child's adoptive, step or natural parent, up to age 26.

A parent-child relationship occurs when the employee or annuitant assumes a parental role and is considered the primary care "parent." Evidence of this relationship may include assuming responsibilities such as providing shelter, clothing, food, child care or education for the child, as well as assuming parental duties, such as providing permission for school activities, health care services, extracurricular, and recreational activities.

A parent-child relationship must be certified at the time of enrollment for each child and annually thereafter up to age 26. Spouses of your recognized natural, adopted, or stepchild are **not** eligible for enrollment.

Employee/Annuitant Information

Name: (First) (M.I.) (Last)

Social Security Number:

What is the date you assumed the primary custodial parental role for the child?

What is your relationship to the child?

Child Information

Name: Date of Birth:

Social Security Number: (First) (M.I.) (Last)

Address (if different from employee/annuitant):

Have you enrolled other children as family members under CCR section 599.500(o)? Yes ☐ No ☐

If yes, what is the number of children enrolled under CCR section 599.500(o)? _____

Note: *A new Affidavit of Parent Child-Relationship form must be submitted for each child.*

Eligibility

I hereby certify I have assumed a parent-child relationship with the child named above, as evidenced by the following:		Internal Use Only (HBO Initials)
1. I have assumed a primary custodial role for this child.	Yes ☐ No ☐ Initials ___	____
2. I am considered the primary care "parent."	Yes ☐ No ☐ Initials ___	____
3. I have assumed responsibility for providing the essential needs for this child, such as food, shelter, clothing, and education.	Yes ☐ No ☐ Initials ___	____
4. Has the child been placed in your care as a result of foster care?	Yes ☐ No ☐ Initials ___	____
5. I am listed as the primary contact on school, health, and other emergency forms.	Yes ☐ No ☐ Initials ___	____
6. I provide parental permission for the child regarding health care services, school, extracurricular, and other activities.	Yes ☐ No ☐ Initials ___	____
7. The child is living with me. (If the child is not currently living with you, please state the reason why.) _____	Yes ☐ No ☐ Initials ___	____
8. I claim the child as my dependent for income tax purposes.	Yes ☐ No ☐ Initials ___	____
9. Other (please explain or attach explanation): _____ _____	Yes ☐ No ☐ Initials ___	____

I recognize this affidavit is a legally binding document. I accept full responsibility for notifying my Health Benefits Officer in writing if there are any changes pertaining to this parent-child relationship. Active employees contact your Health Benefits Officer. Retirees contact CalPERS. I further understand the provision of California Government Code 20085, which states:

(a) It is unlawful for a person to do any of the following:
  (1) Make, or cause to be made, any knowingly false material statement or material representation, to knowingly fail to disclose a material fact, or to otherwise provide false information with the intent to use it, or allow it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by this system.
  (2) Present, or cause to be presented, any knowingly false material statement or material representation for the purpose of supporting or opposing an application for any benefit administered by this system.

I hereby certify under penalty of perjury, that the information provided by me is true and correct to the best of my knowledge. I also agree to provide supporting documentation such as, but not limited to, court records, birth certificate, tax returns, statement of financial liability, or any other documents, when requested by my employer or CalPERS. I understand that each child, other than recognized natural, adopted, or stepchild, for whom I assume a parent-child relationship, must be certified at the time of enrollment and annually thereafter up to age 26.

_____ _____

Employee/Annuitant Signature **Date**

For Employer Use:

I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualified, and acting officer of the below named agency.

☐ I hereby certify I have reviewed the above application and verified the identity of the employee submitting this affidavit.

☐ Based on the information provided and any attached documentation, I am approving the enrollment of this child according to CCR section 599.500(o).

☐ Recommend not approving the enrollment of this child.

_____ _____ _____

Health Benefits Officer Signature **Agency Name** **Date**

_____ _____

Personnel Officer/Human Resources Manager ☐ **Approve** ☐ **Disapprove** **Date**

P.O. Box 942714
Sacramento, CA 94229-2714
TTY for Speech & Hearing Impaired (916) 795-3240
Phone: (888) CalPERS (or **888**-225-7377); Fax (916) 795-1313

1 Certification of Medicare Status

Please complete **Section 1, and either Section 2, 3 or 4**. Sign and date the form and return it to CalPERS at address listed below.

Section 1: Please enter the Member's/Dependent's name and Social Security Number

CalPERS Retiree Name:	**CalPERS Retiree Social Security Number:** _____ - _____ - _____
Member/Dependent Age 65 or older:	**Member/Dependent Social Security Number:** _____ - _____ - _____

Section 2: For Member/Dependent Enrolled in Medicare Parts A and B

☐ I am enrolled in Medicare Part A and Medicare Part B. This is the information reflected on my red, white, and blue Medicare card or Notice of Entitlement from the Social Security Administration:

Name of Medicare Beneficiary
_____

Medicare Claim Number ____ - ___ - _____ - __

HOSPITAL (PART A) effective date ___ - ___ - _____

MEDICAL (PART B) effective date ___ - ___ - _____

Section 3: For Member/Dependent claiming Medicare Ineligibility

☐ I am not eligible for premium-free Medicare Part A (in my own right or through a spouse). I have verified this with the Social Security Administration and have attached documentation of this fact. (Check both boxes that apply to you.)

☐ I did not work for any Social Security covered employment.

☐ I worked for Social Security covered employment, but have less than 40 quarters.

☐ I do not have a spouse (current, former or deceased) that qualifies me for Medicare Part A.

Section 4: For Member/Dependent who works and has Employer Group Health Plan coverage

☐ I have deferred Medicare Part B enrollment due to working beyond age 65 and have coverage in my/my spouse's Employer's Group Health Plan and have attached documentation of this fact.

1. Name of your current employer
_____

2. Name of your Group Health Plan provided by your employer
_____

Under penalty of perjury, I certify that the above information is true and complete.

_____ _____
Signature Date

(_____)_____
Daytime telephone number

Office of Employer & Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
(888) CalPERS 225-7377

CalPERS

GROUP CONTINUATION COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT "COBRA"

PERS-HBD-85 (Rev 08/11)

PERS USE ONLY - DOCUMENT REFERENCE NUMBER

Public Employees' Retirement System
Office of Employer and Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
888 CalPERS (or 888-225-7377)
TTY: For Speech & Hearing Impaired - (916) 795-3240 FAX (916) 795-1313

INSTRUCTIONS FOR COMPLETING THIS FORM ARE ON THE REVERSE SIDE. *PLEASE TYPE*

PART A: ORIGINAL QUALIFYING EVENT AND DATES

1. Type of Action	2. QUALIFYING EVENT	3. EVENT DATE	4. COBRA ENROLLMENT PERIOD
☐ NEW ☐ CHANGE	☐ EMPLOYMENT SEPARATION/TIMEBASE REDUCTION ☐ DIVORCE/LEGAL SEPARATION ☐ CHILD CEASES TO BE A DEPENDENT ☐ DEATH OF AN EMPLOYEE/RETIREE ☐ DEPENDENT CONTINUATION - ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE		FROM ____ 01 ____ TO ____

PART B: ENROLLEE INFORMATION

5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER)	6. SUBSCRIBER (EMPLOYEE/RETIREE)
SOCIAL SECURITY NUMBER ___ — ___ — ___	SOCIAL SECURITY NUMBER ___ — ___ — ___
NAME	NAME
ADDRESS	
CITY, STATE, ZIP	
DAY PHONE ( )	MARRIED ☐ YES ☐ NO
BIRTHDATE	SEX ☐ MALE ☐ FEMALE

PART C: CARRIER INFORMATION

7. NAME AND ADDRESS OF HEALTH PLAN

PLAN CODE: _____ PREMIUM: $_____

PHONE:

PART D: DEPENDENT INFORMATION

ACTION CODE	LIST OF ALL PERSONS (including self) TO BE ENROLLED: (FIRST) (MI) (LAST)	DATE OF BIRTH MO. DAY YR	FAMILY RELATIONSHIP
	SSN		
	(FIRST) (MI) (LAST)		SELF
	SSN		
	(FIRST) (MI) (LAST)		
	SSN		
	(FIRST) (MI) (LAST)		
	SSN		

PART E: ENROLLMENT CHANGES

9. NAME OF PRIOR HEALTH PLAN	11. PERMITTING EVENT CODE	12. PERMITTING EVENT DATE	13. EFFECTIVE DATE OF CHANGE
10. PRIOR PLAN CODE			01

PART F: SIGNATURE OF ENROLLEE

14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.

_____ _____

SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED

PART G: AGENCY INFORMATION

15. AGENCY NAME _____

AGENCY CODE _____ UNIT CODE _____

16. HEALTH BENEFITS OFFICER'S SIGNATURE

DATE RECEIVED_____ PHONE_____

PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the Government Code Sections (20000. et. seq.) and will be used for administration of the Board's duties under the California Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another government agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS P.O. Box 942714, Sacramento, CA 94229-2714

INSTRUCTIONS FOR THE COMPLETION OF FORM HBD-85 (08/2011)

Part A: 1. Type of Action. Check " NEW " if this is a new enrollment.
Check "CHANGE" if family member is added, deleted, or any plan changes.
2. Check applicable Original Qualifying Event and Dates.
3. Provide original event date (separation, date of divorce, etc.).
4. Original COBRA enrollment period.
Examples:
Separation from enrollment 4-15-2010 (Perm. Event) FROM 6-1-2010 TO 11-30-2011
Child attains age 26 on 6-15-2010 (Perm. Event) FROM 7-1-2010 TO 6-30-2013

Part B: 5. Please provide all requested information.
6. If the COBRA enrollee is a former dependent, the employee/retiree must be identified in Box 6.

Part C: 7. Please identify the carrier. The COBRA enrollee must continue the same coverage which he or she had as an employee or as a dependent. Carrier changes are only allowed during the open enrollment period or if the enrollee moves into or out of a carrier's geographic service area. The carrier's name, address, phone number, plan code, and premium can be found in the annual "Health Plan Decision Guide" which is available in all employing agencies. The monthly premium may not exceed 102% of the group rate.

Part D: 8. List all family members to be enrolled, including self.
Action Code: Use "A" to indicate which person is being added (or newly enrolled).
Use "D" to indicate if an individual is being deleted from an existing COBRA enrollment.
An Action Code is not required when changing carriers.
IMPORTANT: The addition or deletion of family members is regulated by time limits which are identical to those for active enrollees (subscribers).

Part E: 9-10 Name and Plan Code of prior health plan if COBRA coverage is being changed.

10-13 To be completed by the Health Benefits Officer.

Part F: 14. Signature of COBRA enrollee and date signed.

Part G: 15-16. To be completed by the (former) employing agency. For (former) dependents of retirees, CalPERS is the "employing agency".

IMPORTANT: It is the responsibility of the COBRA enrollee to report enrollment changes in a timely manner. Enrollment change requests must be submitted in accordance with existing regulations, laws, and the time limits applicable to the Public Employees' Medical and Hospital Care Act. All change requests are directed through the agency listed in Part G.

Health Benefits Branch
P.O. Box 942714
Sacramento, CA 94229-2714
888 CalPERS (or **888**-225-7377) FAX: (916) 795-1313
TTY: For Speech & Hearing Impaired (916) 795-3240

CalPERS

HBD-85R (Rev 12/2010)

SUBJECT: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

General Information - Election

This form is to be used by Retirees only. For active members, please use the HBD-85 form.

The Federal COBRA legislation allows the continuation of health and dental coverage to family members who lost their eligibility for coverage as dependents on or after August 1, 1986, for one of the following reasons:

a. Divorce or legal separation
b. Attainment of age 26 (child)
c. Death of employee/annuitant (if enrolled family member is not eligible for a monthly survivor/beneficiary allowance from CalPERS)

The coverage can be continued for up to 36 months, but the premium payment (102% of the group rate) is the responsibility of the enrollee. No state contribution is available to pay for the COBRA coverage. To enroll under COBRA, please fill out the information below:

Name and Social Security Number of (former) prime life enrollee:

_____ SSN: ____ - ____ - _____

Name and Social Security Number of COBRA enrollee, if different from above:

Name: _____ SSN: ____ - ____ - _____

Address: _____

Daytime Phone No: ( ) _____

QUALIFYING EVENTS: Length of coverage is 36 months.

☐ Divorce or legal separation ☐ Death of employee/annuitant

☐ Child attained age 26

Date of the above qualifying event: _____

ELECTION TO ENROLL IN OR DECLINE COBRA CONTINUATION COVERAGE:

Health Benefits Enroll ☐ Decline ☐

Dental Coverage Enroll ☐ Decline ☐

Signature of COBRA Enrollee: _____ Date: _____
(mm/dd/yyyy)

Please return this election within 60 days after receipt to the address indicated above. CalPERS will prepare the actual enrollment document and send a copy to the COBRA enrollee and to the carrier. A premium check payable to the carrier may be enclosed, or the carrier will bill the enrollee directly. The effective date for COBRA coverage is the same as the date on which coverage as a dependent is terminated.

CalPERS
Public Employees' Retirement System
Office of Employer and Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
www.calpers.ca.gov

Benefit Services Division
P.O Box 942716
Sacramento, CA 94229-2716
Telecommunications Device for the Deaf – (916) 795-3240
(916) 795-3848; (800) 352-2238; Fax (916) 795-3933

☐ Send me information about the Electronic Fund Transfer program. This request does not constitute an agreement on my part to enroll in this program.

ADDRESS CHANGE AUTHORIZATION

NAME (Please Print or Type) _____

Social Security Number _____

PLEASE INDICATE THE CHANGE(S) YOU ARE REQUESTING

☐ Change address for mailing my warrant/s (check/s).

☐ Change address for mailing other information.

PLEASE FILL IN YOUR CORRECT MAILING ADDRESS

In Care of (if applicable) _____

Mailing Address _____

City _____ State _____ Zip Code _____

IF YOU WOULD LIKE YOUR WARRANT(S) MAILED TO YOUR FINANCIAL INSTITUTION, PLEASE FILL IN THE INSTITUTION'S MAILING ADDRESS

Name of Institution _____ _____
Deposit Account Number

Mailing Address _____

City _____ State _____ Zip Code _____

SIGNATURE OF PAYEE _____

☐ I am a Guardian/Conservator or have Power of Attorney for the person entitled to the allowance. (A copy of Guardian/Conservatorship/Power of Attorney papers must be on file with CalPERS before an address change will be completed.)

Telephone number of person signing change request: (_____) _____

Special Power of Attorney

888 CalPERS (or **888**-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240 • Fax (916) 795-3934

Section 1 — Creation of Durable Power of Attorney for Retirement-Related Business

When completing this form, please be sure to print the requested information.

For the purpose of this form, a principal is defined as a person who empowers another to act as a representative on their behalf.

Name of Principal (First Name, Middle Initial, Last Name) | Social Security Number

Address | County

City | State | ZIP | Daytime Phone

By this document I intend to create a durable power of attorney by appointing the person(s) named below to make retirement-related decisions for me as allowed by the California Probate Code. This power is expressly limited to decisions relating to my financial and health benefits under the California Public Employees' Retirement System, the Legislators' Retirement System, or the Judges' Retirement System I or II — hereinafter CalPERS, LRS, JRS I and JRS II, respectively.

Section 2 — Designation of Attorney-In-Fact

You have the option of designating more than one attorney-in-fact.

If you appointed more than one attorney-in-fact, and you want each attorney-in-fact to be able to act alone, check the appropriate box. If you do not check a box, or if you check "jointly," then all of your attorneys-in-fact must act or sign together. Granting joint authority to two or more attorneys-in-fact is exercisable only by their unanimous action. If you choose to have your attorneys-in-fact act jointly, and one is unavailable because of absence, illness, or other temporary incapacity, the other attorney(s)-in-fact may exercise their authority under the power of attorney.

Name of attorney-in-fact

Address | County

City | State | ZIP | Daytime Phone

Name of attorney-in-fact

Address | County

City | State | ZIP | Daytime Phone

Name of attorney-in-fact

Address | County

City | State | ZIP | Daytime Phone

I have designated more than one attorney-in-fact. They are to act (mark one box only):

☐ Jointly ☐ Separately ☐ Alternately, in the numerical order specified above. If you mark "Alternately," you must number the attorneys-in-fact in the order in which they are to act.

Put your name and Social Security number at the top of every page.

Name of Principal

Social Security Number

Section 3

General Statement of Authority Granted

I hereby grant to my attorney-in-fact full power and authority to transact matters on my behalf relating to CalPERS, LRS, JRS I or JRS II. I understand that this authority is granted to the attorney-in-fact designated by me even if that person is related to me by blood, marriage, or legal domestic partnership. By signing this *Special Power of Attorney* form I intend that:

- My attorney-in-fact (☐ is; ☐ is not) authorized to select any payment option available under the retirement plan, even though it may reduce the monthly allowance that would otherwise be paid to me during my lifetime.
- My attorney-in-fact (☐ is; ☐ is not) authorized to designate or change my beneficiary.
- My attorney-in-fact (☐ is; ☐ is not) authorized to designate him or herself as my beneficiary.

On the following lines you may give special instructions limiting the powers granted to your attorney(s)-in-fact.

Section 4

Duration of Power of Attorney

Please be careful in choosing when you want your power of attorney to commence or terminate.

Please check one box to indicate your choice.

Unless I indicate otherwise, this power of attorney is effective immediately and will continue until it is revoked. My attorney-in-fact is hereby instructed to notify CalPERS in writing of my disability, incapacity, or death immediately upon its occurrence.

☐ This special Durable power of attorney is to commence immediately and to remain in effect for my lifetime or until I specifically cancel it.

☐ This special Limited power of attorney is to commence on _____ and terminate on
Date (mm/dd/yyyy)

_____.
Date (mm/dd/yyyy) or Event

☐ This special Contingent power of attorney is to commence only upon a determination that I am incapacitated and/or unable to handle my own affairs. The determination of whether I am incapacitated and/or unable to handle my own affairs shall be made by

_____.
Name or Title of Person to make the determination

☐ This special General power of attorney is to terminate in its entirety if I become incapacitated.

Put your name and Social Security number at the top of every page.

Name of Principal

Social Security Number

Section 5

Notice to Person Executing Durable Power of Attorney

Agent is the attorney-in-fact

The authority granted by the CalPERS *Special Power of Attorney* form is limited to matters relating to CalPERS, LRS, JRS I and JRS II. The person designated as your attorney-in-fact does not have any authority over your other real or personal property. If you wish that your attorney-in-fact have authority over your real and/or personal property, it is recommended that you seek legal counsel.

You may notice that the language contained in the following (Warning) statement refers to more extensive authority than granted by the CalPERS *Special Power of Attorney*. This (Warning) statement is required by Probate Code Section 4128 and must be included in all preprinted durable power of attorney forms even though the CalPERS *Special Power of Attorney* does not authorize your attorney-in-fact to do many of the things mentioned in the following (Warning) statement. Also, if you are concerned with the (Warning) statement or the extent of the authority being granted by the CalPERS *Special Power of Attorney* form, we again urge you to consult with an attorney.

(Warning): Notice to Person Executing Durable Power of Attorney

A durable power of attorney is an important legal document. By signing a durable power of attorney, you are authorizing another person to act for you, the principal. Before you sign this durable power of attorney, you should know these important facts:

- Your agent (attorney-in-fact) has no duty to act unless you and your agent agree otherwise in writing.
- This document gives your agent the powers to manage, dispose of, sell, and convey your real and personal property, and to use your property as security if your agent borrows money on your behalf. This document does not give your agent the power to accept or receive any of your property, in trust or otherwise, as a gift, unless you specifically authorize the agent to accept or receive a gift.
- Your agent will have the right to receive reasonable payment for services provided under this durable power of attorney unless you state otherwise in this power of attorney.
- The powers you give your agent will continue to exist for your entire lifetime, unless you state that the durable power of attorney will last for a shorter period of time or unless you otherwise terminate the durable power of attorney. The powers you give your agent in this durable power of attorney will continue to exist even if you can no longer make your own decisions regarding the management of your property.
- You can amend or change this durable power of attorney only by executing a new durable power of attorney or by executing an amendment through the same formalities as an original. You have the right to revoke or terminate this power of attorney at any time as long as you are competent.
- This durable power of attorney must be dated and must be acknowledged before a notary public or signed by two witnesses. If it is signed by two witnesses, they must witness either (1) the principal's signing of the power of attorney or (2) the principal's acknowledgement of his or her signature. A durable power of attorney that may affect real property should be acknowledged before a notary public so that it can easily be recorded.
- You should read this durable power of attorney carefully. When effective, this durable power of attorney will give your agent the right to deal with property that you now have or might acquire in the future. This durable power of attorney is important to you. If you do not understand the durable power of attorney or any provision of it, you should obtain the assistance of an attorney or other qualified person.

Put your name and Social Security number at the top of every page.

Name of Principal | Social Security Number

Section 6

Notice to Person Accepting the Appointment of Attorney-in-Fact

By acting or agreeing to act as the agent (attorney-in-fact) under this power of attorney you assume the fiduciary and other legal responsibilities of an agent. These responsibilities include:

- The legal duty to act solely in the interest of the principal and to avoid conflicts of interest.
- The legal duty to keep the principal's property separate and distinct from any other property owned or controlled by you.

You may not transfer the principal's property to yourself without full and adequate consideration or accept a gift of the principal's property unless this power of attorney specifically authorized you to transfer property to yourself or accept a gift of the principal's property. If you transfer the principal's property to yourself without specific authorization in the power of attorney, you may be prosecuted for fraud and/or embezzlement. If the principal is 65 years of age or older at the time the property is transferred to you without authority, you may also be prosecuted for elder abuse under Penal Code Section 368. In addition to criminal prosecution, you may also be sued in civil court.

I have read the foregoing notice and I understand the legal and fiduciary duties that I assume by acting or agreeing to act as the agent (attorney-in-fact) under the terms of this power of attorney. Lastly, the principal's benefit shall not be subject to execution, process, or assignment under California Public Employees' Retirement Law Section Code 21255.

Print Name of Agent

Signature of Agent | Date (mm/dd/yyyy)

Print Name of Agent

Signature of Agent | Date (mm/dd/yyyy)

Print Name of Agent

Signature of Agent | Date (mm/dd/yyyy)

Section 7

Principal's Acknowledgement & Execution

To be completed and signed by the Principal.

I am of sound mind and either understand my elections or talked with an attorney. I am executing this legal document under my own free will.

Date Executed (mm/dd/yyyy) | City | State

Signature of Principal | County

Name of Principal (printed) | Social Security Number

Put your name and Social Security number at the top of every page.

Name of Principal | Social Security Number

Section 8

To be completed by two witnesses who are not named as attorneys-in-fact.

Witness Information

I have witnessed the principal's signature or the principal's acknowledgment of the signature designating power of attorney. I attest to the principal's knowledge that I am of sound mind. I am an adult at least 18 years old and not the attorney-in-fact. My signature certifies that the principal is known to me, is the same person who signed and dated this affidavit, and that I am of sound mind.

Signature of Witness 1 | Name of Witness 1 (printed)

Address | Date

City | State | ZIP

Signature of Witness 2 | Name of Witness 2 (printed)

Address | Date

City | State | ZIP

Section 9

To be completed by a Notary Public.

This section does not need to be completed if you have completed Section 8. CalPERS images these documents. Please be advised embossed seals may not appear when this document is reviewed. An inked stamp is preferred.

Notary Public Acknowledgement

Notary

State | County

On _____ before me _____, personally appeared
Date (mm/dd/yyyy) | Printed Name of Notary Public

_____, who proved to me on the basis of satisfactory evidence
Name of Principal

to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I certify under ***Penalty of Perjury*** under the laws of the State of California that the Foregoing paragraph is true and correct.

Witness my hand and official seal.

Signature of Notary Public | Notary Seal

Print Name

Mail to: **CalPERS Benefit Services Division • P.O. Box 942716, Sacramento, California 94229-2716**

CVS CAREMARK | Mail Service Order Form

Mail this form to:

CVS CAREMARK
PO BOX 94467
PALATINE, IL 60094-4467

Enter ID # below if not shown or if different from above

Prescription Plan Sponsor or Company Name

Please use **blue or black ink, capital letters,** and fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

FOR FASTEST SERVICE, order refills at www.caremark.com or call the number on your prescription benefit identification card.

A Shipping Address. To ship to an address different from the one printed above, please make changes here.

Last Name | First Name | MI | Suffix (JR, SR)

Street Name | Apt./Suite #

○ **Use this address for this order only.**

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

B Refills. To order mail service refills, enter your prescription number(s) here.

1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____ 8)_____

Please fold here →

* WEB *

We may package all of these prescriptions together unless you tell us not to.

C **Tell us about the people getting prescriptions.** If there are more than two people, please complete another form.

1st person with a refill or new prescription. This person needs: ○ Spanish forms and labels

Last Name | First Name | MI | Suffix (JR,SR)

NICKNAME | Gender: ○ M ○ F | Date of Birth: MM-DD-YYYY

Your E-Mail: _____ Date new prescription written: _____

Doctor's Last Name | Doctor's First Name | Doctor's Phone #

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

Health Information: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid ○ Other: _____

2nd person with a refill or new prescription. This person needs: ○ Spanish forms and labels

Last Name | First Name | MI | Suffix (JR,SR)

NICKNAME | Gender: ○ M ○ F | Date of Birth: MM-DD-YYYY

Your E-Mail: _____ Date new prescription written: _____

Doctor's Last Name | Doctor's First Name | Doctor's Phone #

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

Health Information: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid ○ Other: _____

D **Special Instructions:** _____

E **How would you like to pay for this order?** Fill in the oval to choose a payment.

○ **Electronic Check.** Pay from your bank account. First time users register online or call Customer Care.

○ **Bill Me Later®.** Works like a credit card. First time users register online or call Customer Care.

○ **Credit or Debit Card.** (VISA®, MasterCard®, Discover®, or American Express®)

○ Fill in this oval to use your card on file.

○ Fill in this oval to use a new card or to update your card expiration date.

Exp.Date MMYY

Credit Card Holder Signature/Date

○ **Check or Money Order.** Amount: $.

- Make check or money order out to CVS Caremark.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to $40.

Payment for Balance Due and Future Orders: If you chose Electronic Check, Bill Me Later®, or a Credit or Debit Card, we will also use it to pay for any balance that you owe and for future orders.

○ Fill in this oval if you **DO NOT** want to use this payment method for future orders.

Regular delivery is free and will take 7 to 10 days from the day you send this form.

If you want faster delivery, choose:

○ **2nd Business Day ($17)** **Business days are only Monday-Friday**

○ **Next Business Day ($23)**

- Faster delivery charges may change.
- Faster delivery is for shipping time, not processing time.
- Faster delivery can only be sent to a street address, not a PO box.

Please fold here → * WEB *

Your Personal Prescription Benefit Program

PERS Choice and PERS Select

	Retail Pharmacy Network For short-term medications (Up to a 30-day supply)	**Mail Service Pharmacy or Maintenance Choice** For long-term medications (Up to a 90-day supply)
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**$5** for a generic prescription	**$10** for a generic prescription
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	**$20** for a preferred brand-name prescription	**$40** for a preferred brand-name prescription
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	**$50** for a non-preferred brand-name prescription	**$100** for a non-preferred brand-name prescription
Partial Waiver of Non-Preferred Brand copayment**	**$40** for a Partial Waiver of non-preferred brand	**$70** for a Partial Waiver of non-preferred brand
Maintenance Medications at Retail	After 2nd fill you will pay the appropriate mail service copayment	None
Maximum Out-of-Pocket		$1000 per individual *

Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the generic copayment.
Discretionary drugs are subject to a 50% co-insurance. Discretionary drugs are products used to treat non-life threatening conditions such as erectile dysfunction.
*The Mail Service Out-of-Pocket Maximum excludes Non-Preferred Brand-Name Medication copayments, Discretionary Drug co-insurance, and "Member Pays the Difference" differential.
**To obtain a partial copayment waiver, your physician must document the necessity for the non-preferred product vs. the preferred product(s) and the available generic alternative(s).

00001

Where to fill your prescription

Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication:

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the retail network.

- Choose from more than 64,000 network pharmacies nationwide, including independent pharmacies, chain pharmacies and 7,100 CVS/pharmacy locations.
- Find a participating pharmacy at www.caremark.com/calpers

Tip: To avoid filling out claims paperwork, bring your ID Card with you when you pick up your prescription, and use a pharmacy in the retail network.

Long-term medications are taken regularly for chronic conditions, such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money by using mail service for these prescriptions.

Choose **one** of four easy ways to start using the Mail Service program:

1. Bring your prescription to a CVS/pharmacy location
2. Fill out and send in a mail service order form – use the one included in this welcome kit or print one at www.caremark.com/calpers
3. Use the FastStart® tool found on www.caremark.com/calpers
4. Call FastStart toll-free at 1-800-875-0867

Customer Care

If you have questions about your prescriptions or benefits, you can contact Customer Care 24 hours a day, seven days a week. You can either e-mail customerservice@caremark.com or call toll-free at 1-877-542-0284. For TDD assistance, please call toll-free 1-800-863-5488.

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

CVS CAREMARK

00001

NUBAAG

Use Maintenance Choice to Fill Your Long-Term Medications

Maintenance Choice® offers you choice and savings when it comes to filling long-term prescriptions. Now you have **two ways to save:**

CVS Caremark Mail Service Pharmacy:

- Enjoy convenient home delivery
- Receive your medications in private, tamper-resistant and (when needed) temperature-controlled packaging
- Talk to a pharmacist by phone

CVS/pharmacy:

- Pick up your medication at a time that is convenient for you
- Enjoy same-day prescription availability
- Talk with a pharmacist face-to-face

Plus, you can easily order refills and manage your prescriptions anytime at **www.caremark.com/calpers**.

To Get Started

The following chart provides detailed steps to help you start enjoying all the benefits of Maintenance Choice.

IF YOU WOULD LIKE…	THEN…
To continue with mail service	**You don't have to do anything.** We'll continue to send your medications to your location of choice.
To pick up at CVS/pharmacy	**Please let us know.** You can do so quickly and easily. Choose the option that works best for you: • Register or log into www.caremark.com/calpers to select a CVS/pharmacy location for pick up • Visit your local CVS/pharmacy and talk to the pharmacist • Call us toll-free at 1-877-542-0284 and we'll handle the rest
To sign up for mail service for the first time	**You can do so easily online or by phone.** • Register or log into www.caremark.com/calpers, select "Start a New Prescription," then click on "FastStart®" • Call FastStart toll-free at 1-800-875-0867. We'll handle the rest
More information	**Give us a call.** Call us toll-free at 1-877-542-0284.

Before you reach your 30-day fill limit and your out-of-pocket cost increases, we will contact you to help you get started with Maintenance Choice. We'll then help you get a 90-day prescription from your doctor so you can choose to fill it through mail service or at a CVS/pharmacy.

5707-SML-SUM_60-0110

CVS CAREMARK

Office of Employer and Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
(888) CalPERS (225-7377)
TDD - (916) 795-3240
FAX (916) 795-1277

MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT

COMPLETE ALL ITEMS. INCOMPLETE FORMS WILL BE RETURNED CAUSING DELAY IN BENEFITS.

MEMBER PART A: THE MEMBER IS TO COMPLETE THE INFORMATION IN PART A: MEMBER INFORMATION	DEPENDENT INFORMATION
NAME:_____	**NAME:**_____
SOCIAL SECURITY NUMBER (SSN)_____	**SSN**_____
ADDRESS:_____	**ADDRESS:**_____
TELEPHONE ( )_____	**DATE OF BIRTH:**_____

PART B: DEPENDENT AUTHORIZATION: *The **dependent**, or person authorized to act in his or her behalf, is to complete the information requested in PART B prior to giving the form to the physician for completion:*

I hereby authorize my attending physician_____ to furnish and disclose all facts concerning my disability that are within his or her knowledge and to allow inspection, and provide copies, of any medical records concerning my disability that are under his or her control. This authorization shall be valid for a period of one year from the date of my signature or the effective date of this claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, CalPERS may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand that CalPERS will keep confidential the information which is provided pursuant to this authorization, and that it will be used solely to determine and act upon my request for this benefit.

_____ _____
Signature of Dependent **OR** Date Signed

_____ _____
Person authorized to act on his/her behalf Relationship to the dependent

PHYSICIAN PART C: *The **physician** is to complete all requested information in PARTS C and D. All responses must be legible. Mail this completed form to CalPERS at the address found at the top of this page.*

Please DO NOT send information copied directly from the patient's medical record at this time.

Dear Doctor:
The patient requests you to complete this **Medical Report** form. It will assist CalPERS in processing his or her claim for health insurance as a disabled dependent under his or her parent's or guardian's health plan. By providing the medical information promptly, you will help the patient expedite the claims process.

Medical Report	
1.	I attended the patient for the current disabling medical problem or condition from _____ to _____. At intervals of _____. I last examined the patient on _____.
2.	Medical History (related to disability): Date of Disability Onset:_____
3.	Diagnosis (REQUIRED): _____ ICD-9 Disease Code, Primary (Required) : _____ ICD-9 Disease Code(s), Secondary : _____ DSM IV Code(s) (if any) : _____
4.	Objective Clinical Findings/Detailed Statement of Symptoms: (see page 2, Items 6 and 7 for additional findings)
5.	Current Treatment(s) and /or Medication(s)(rendered to the patient for this disability): ☐ The patient is not currently receiving treatment(s) and/or medications for this disability. (Check if applicable.)

(See page 2 of this for additional required information.)

MEMBER:_____ DEPENDENT NAME:_____
SSN: _____ SSN: _____

Medical Report	
6	Functional Assessment of Activities of Daily Living (ADLS): Indicate the patient's degree of physical or mental disability in the following ADLs using a scale of 1 to 10. One (1) indicates the ADL is not affected by the patient's disability. A ten (10) indicates the patient is completely disabled in this ADL skill or ability. These functional disabilities limit the patient's capacity for self support. **Mobility Skills**: ____walking, ____sitting, ____standing, ____lifting, ____bending **Self-Care Skills**: ____feeding, ____bathing, ____toileting, ____dressing **Sensory Skills**: ____hearing, ____seeing, ____speech, ____touch **Cognitive Skills**: ____judgment, ____memory, ____planning/follow through, ____thinking/processing information
7.	Psychological / Psychiatric Assessment: List the specific psychological / psychiatric symptoms or behaviors, if any, that affect the patient's ADLs and limit his or her capacity to be self-supporting:

PART D: Medical Certification of Disability and Incapacity of Self Support: For purposes of this benefit, a CalPERS member can retain his or her eligibility for health benefits as a family member if he or she is unmarried and incapable of self-support (i.e., not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 23 years of age.

1. Based upon your examination, does the patient currently have a physically or mentally disabling injury, illness or condition?
   ____ NO, the patient does NOT have a physically of mentally disabling injury, illness or condition.
   ____ YES (Please answer Question 2.)

2. In your medical or psychiatric opinion, please select **A**, **B**, or **C**:
   ____**A**. The patient's current disability DOES NOT render him or her incapable of self-support.

   ____**B**. The patient's current disability DOES render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by _____.
   (projected DATE—mm / yy)
   If the condition is likely to improve or resolve, make SOME "estimate" of when this will occur.
   Please DO NOT leave the DATE blank. Answers such as "indefinite" or don't know" will not suffice.

   ____**C.** The patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self support within the foreseeable future (e.g., more than 5 years).

I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self support, and that I am a _____, _____
(Type of Physician) (Specialty, if any)
licensed to practice by the State of _____.

PRINT, TYPE or STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE and HIS OR HER ADDRESS, TELEPHONE AND FAX NUMBERS:

_____ _____
PHYSICIAN'S NAME AS SHOWN ON LICENSE ORIGINAL SIGNATURE OF ATTENDING PHYSICIAN

_____ _____
LOCAL ADDRESS STATE LICENSE NUMBER

_____ (_____)_____
CITY STATE TELEPHONE NUMBER

_____ (_____)_____
DATE FAX NUMBER

PART E: CalPERS USE ONLY:

____ Claim approved for enrollment through _____ _____
DATE (for next review) REVIEWED BY

____ Claim rejected. _____
DATE

PRIVACY INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System (CalPERS) to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections (20000. et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to supply the information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, PO Box 942702, Sacramento, CA 94229-2702.

Section 7(b), of the Privacy Act of 1974 (Public Law 93—579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

The Office of Employer and Member Health Services of the California Public Employees' Retirement System requests each enrollee's Social Security account number on a voluntary basis. However, it should be noted that due to the use of Social Security account numbers by other agencies for identification purposes, the Office of Employer and Member Health Services may be unable to verify eligibility for benefits without the Social Security account number.

The Office of Employer and Member Health Services of the California Public Employees' Retirement System uses Social Security account numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and state contribution for state employees
3. Billing of contracting agencies for employee and employer contributions
4. Reports to the California Public Employees' Retirement System and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals/complaints/grievances with health plan carriers

Office of Employer and Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
(888) CalPERS (225-7377)
TDD - (916) 795-3240
FAX (916) 795-1277

MEMBER QUESTIONNAIRE for the CalPERS DISABLED DEPENDENT BENEFIT

MEMBER: PLEASE COMPLETE ALL ITEMS. INCOMPLETE FORMS WILL BE RETURNED CAUSING A DELAY IN BENEFITS.

PART A: **MEMBER INFORMATION:**	**DEPENDENT INFORMATION:**
Name: _____ **Social Security Number (SSN):** _____-_____-_____ **Address:** _____ **Telephone:** (____)_____	**Name:** _____ **Social Security Number (SSN):** _____-_____-_____ **Address:** _____ **Date of Birth:** _____

PART B: Please provide the following information about the dependent who is seeking initial or continued enrollment or recertification in the health plan under the disabled dependent benefit. For purposes of this benefit, a person is considered disabled if the person is incapable of self-support (i.e., incapable of any substantial gainful activity) as a result of a physical or mental disabling injury, illness or condition. Mail this completed form to the above address.

MEMBER QUESTIONNAIRE			
			Marital Status
1.	**Yes**	**No**	Is the dependent married or has he or she ever been married? If yes, do not complete the remainder of this form. The dependent is **NOT** eligible to continue enrollment in the CalPERS Health Benefit Program.
			Health Insurance and Health Care
2.			Is the dependent entitled to:
	Yes	**No**	Medi-Cal? (If yes, attach a copy of the dependent's Medi-Cal card.)
	Yes	**No**	Medicare Part A (hospital care)? (If yes, attach a copy of the dependent's Medicare card)
	Yes	**No**	Medicare Part B (medical care)? (If yes, attach a copy of the dependent's Medicare card)
	Yes	**No**	Other insurance? (If yes, specify the plan name and type of coverage)
3.	**Yes**	**No**	Has the dependent received In-Home Supportive Services or in-home skilled nursing care in the past year?
			Income and Support
4.	**Yes**	**No**	Is the dependent economically dependent upon you for his or her support? (If yes, attach a list of the dependent's monthly living expenses that you provide including housing, food, clothing, medical, etc.)
5.			Is the dependent entitled to receive:
	Yes	**No**	Social Security Disability Insurance (SSDI)?
	Yes	**No**	Supplemental Security Income (SSI)?
6.	**Yes**	**No**	Does the dependent currently attend school? (If yes, specify the name of the school(s) and course(s) of study)
			Employment History
7.	**Yes**	**No**	Has the dependent *ever* worked (including work through a sheltered workshop)? (If yes, attach the date(s) of employment and employer name(s) and address(es).)
8.	**Yes**	**No**	Is the dependent working now?
9.	**Yes**	**No**	If the answer to question 7 or 8 is yes, attach proof of the dependent's earnings for the current calendar year (January to December) and the two previous years.

PART C: CERTIFICATION:
I hereby certify that, to the best of my knowledge, the above information is complete and correct.

_____ _____
Member Name Date

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5. Coordination of benefits among carriers
6. Resolve member appeals/complaints/grievances with health plan carriers

Office of Human Resources and Equal Opportunity
12345 El Monte Road, Los Altos Hills, CA 94022

EMPLOYEE ADDRESS CHANGE FORM

_____ F/T Faculty
_____ Classified/Administrator
_____ P/T Faculty
_____ Temporary Employee
_____ Student Employee

FH _____ DA _____ CS _____

Effective Date: _____

_____ _____
NAME Employee Identification Number

_____ _____ _____
STREET ADDRESS CITY & STATE ZIP CODE

(_____)_____ _____
TELEPHONE EXTENSION

If you have an unlisted number, please list it below. This number will only be available to your Supervisor/ Managers and appropriate staff of Human Resources.

(_____)_____
UNLISTED TELEPHONE NUMBER

_____ _____
EMPLOYEE'S SIGNATURE DATE

RETURN THIS FORM TO THE OFFICE OF HUMAN RESOURCES
Mark this box if your check mailing address is different then your home address ☐

Revised: 3/29/12

FOOTHILL-DE ANZA
Community College District
Office of Human Resources and Equal Opportunity

RETIREE/SURVIVING SPOUSE
ADDRESS CHANGE FORM

For HR use only
Banner _____

CHANGE EFFECTIVE DATE: ____/____/____

RETIREE/SURVIVOR INFORMATION

NAME _____

SOCIAL SECURITY NUMBER ___ - ___ - ____

NEW OR MOST RECENT CONTACT INFORMATION

NEW STREET ADDRESS _____

ADDRESS (Line 2) _____

APARTMENT/UNIT # _____

CITY _____

STATE _____ **ZIP CODE** _____

IN CARE OF ("c/o") _____ ☐ *Not Applicable*

HOME PHONE ( ) _____ **EMAIL ADDRESS:**

CELL PHONE ( ) _____ _____ @ _____

EMERGENCY/ALTERNATIVE CONTACTS

(These individuals should ***not*** share the same address and/or phone number as you.)

1

Name _____ **Relationship to you** _____
(child, other relative, neighbor, nurse assistant (CNA), etc.)

Address _____ **Phone(s)** ( ) _____

_____ ( ) _____

Authorized Power of Attorney? ☐Yes ☐No

2

Name _____ **Relationship to you** _____
(child, other relative, neighbor, nurse assistant (CNA), etc.)

Address _____ **Phone(s)** ( ) _____

_____ ( ) _____

Authorized Power of Attorney? ☐Yes ☐No

RETIREE SIGNATURE _____ **DATE** _____

Submit this form to:

FAX	**(650) 949-2831**	**EMAIL**	**MyBenefits@fhda.edu**
MAILING ADDRESS	Foothill-De Anza Community College District ***ATTN: Benefits Department*** 12345 El Monte Road, Los Altos Hills, CA 94022		

Foothill-De Anza Community College District 12345 El Monte Road, Los Altos Hills, CA 94022 • http://hr.fhda.edu/benefits

FOOTHILL-DE ANZA
Community College District