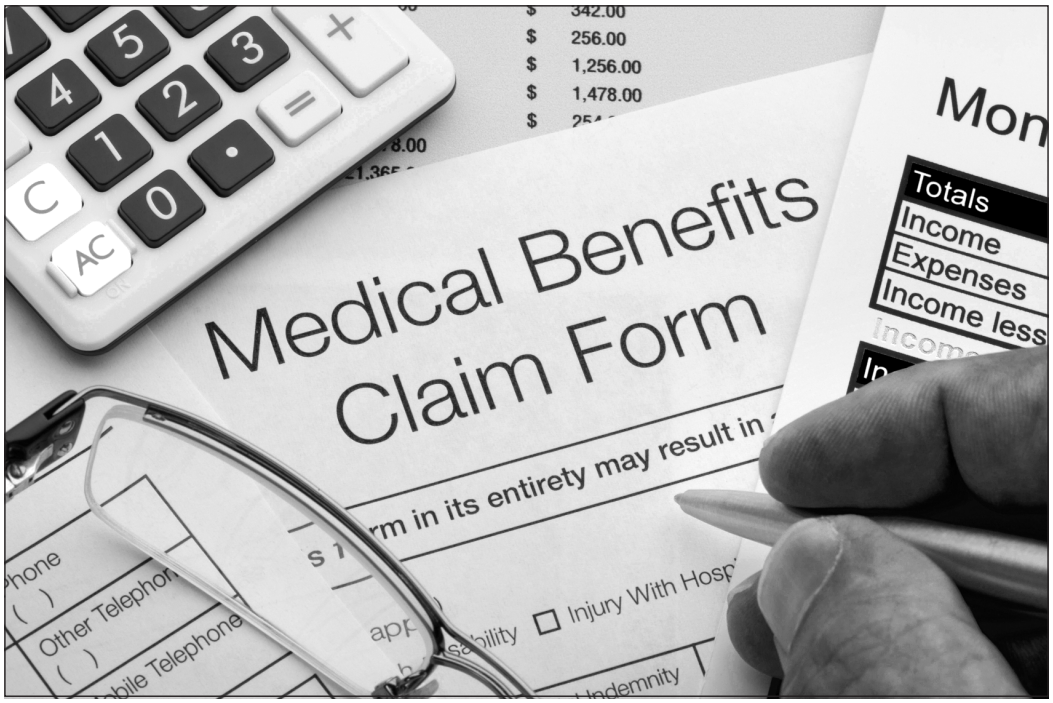

FHDA Benefits Guide – 2013 Plan Year

January 1 – December 31, 2013

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 Health Carriers:

Blue Shield HMOs:

*(*Access+ / Net Value / 65 Plus)_____ Phone: (**800 997-3770** _____ **www.blueshieldca.com**

Kaiser Permanente_____ Phone: **(800) 464-4000** _____ **www.kp.org**

Anthem Blue Cross PPOs

(PERSCare / PERS Choice / PERS 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 Hills, 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 — For
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 September 10 – October 5, 2012, Monday – Friday, 8 a.m. – 8 p.m.

SECOVA Customer Service _____ Phone: **(866) 364-2594**
eFax: **(877) 635-4606**
E-mail: **fhda.retireebenefits@SECOVA.com**

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

■ RETIREMENT

CalPERS Website: _____ **http://www.calpers.ca.gov**
CalSTRS Website: _____ **http://www.calstrs.ca.gov**

Table of Contents

Table of Contents

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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, Dental and Vision Coverage, Prescription Coverage for the PERSCare, PERS Choice and PERS Select Plans, 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 UnitedHealthcare to the CalPERS Health Program. This *Guide* is intended to provide information for the 2013 Plan Year.

The Next Benefits Plan Year is Calendar Year 2013
The effective dates of the next benefits period are January 1, 2013 through December 31, 2013.

Open Enrollment is September 10 – October 5, 2012 (5:00 p.m.)
The CalPERS Health benefit plans operate on a calendar year cycle. This means Open Enrollment is scheduled each fall. Open Enrollment for CalPERS coverage for the 2013 Plan Year is **September 10 – October 5, 2012 (5:00 p.m.).**

Open Enrollment Workshops
We will be holding a benefits fair, retiree Open Enrollment workshops and enrollment labs for active employees to inform you about the plan details and to assist you with enrolling. Information about these information sessions are included in this booklet. It is imperative that you meet the final deadline to ensure coverage.

Six CalPERS Benefit Plan Choices
The CalPERS Health Program provides six plan choices, as follows:

- **Three HMOs:** Kaiser, Blue Shield Access+ and Blue Shield NetValue
- **Three PPOs:** PERSCare, 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 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: CVS Caremark

(For the Three PPO Plans: PERSCare, PERS Choice and PERS Select)

The CalPERS Health Program uses CVS Caremark as its medical prescription provider for its three PPO plans (PERSCare, PERS Choice and PERS Select). All active employees and retirees who elect a PPO plan will have prescription coverage through CVS Caremark for the 2013 Plan Year .

Prescription Refills
Call CVS Caremark at **877-542-0284** or use the website **www.caremark.com/calpers.**

Specialty Pharmacy
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
CVS Caremark is 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.

Please see the relevant sections for Active Employees or Retirees; go to **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/
By Mail: **Foothill-De Anza Community College District**
Office of Human Resources/Benefits Unit
12345 El Monte Road
Los Altos Hill, CA 94022

FHDA Benefits Fair for the 2013 Plan Year

for Active Eligible Employees, Eligible Part-Time Faculty & Retirees/Survivors/COBRA Enrollees

Foothill-De Anza District Benefits Unit Available to Answer Your Questions and Provide Information:

Voluntary Benefit Plan Reps Also Available:
Life Insurance, Flexible Spending Accounts
and Supplemental Retirement Planning (403b & 457)

What's Happening	Date	Time	Location
Benefits Fair **Open to All Benefit-Eligible Employees and Retirees** (No presentation at the Fair; vendors and Benefits staff available for Q&A)	Fri., Sept. 21, 2012	12 – 2 p.m.	De Anza College Campus Center Conference Rooms A & B
Retiree Workshops — First Priority for Retirees	Fri., Sept. 21, 2012	11:45 a.m. – 12:45 p.m.	De Anza College – Forum 1
Dates & Locations for Individual Assistance: ***Active Employee iElect Online Enrollment Assistance and Individual Q & A***			
Mon., Oct. 1, 2012 Tue., Oct. 2, 2012 Wed, Oct. 3, 2012	11:30 a.m. – 1 p.m. 11:30 a.m. – 1 p.m. 11:30 a.m. – 1 p.m.	Media & Learning Center, Room 243 Media & Learning Center, Room 243 Media & Learning Center, Room 243	De Anza College De Anza College De Anza College
Wed, Oct. 3, 2012 Thu., Oct. 4, 2012	11:30 a.m. – 1 p.m. 11:30 a.m. – 1 p.m.	District Benefits Office District Benefits Office	Foothill College Foothill College

Open Enrollment Period
September 10, 2012 – October 5, 2012 (5 p.m.)
Meet the Deadline!

FHDA Benefits Fair for the 2013 Plan Year

Information About the CalPERS Heath Care Plans and Other Benefits

Health Plan Vendors Include:

- FHDA Benefits Unit
- Delta Dental
- VSP Vision

Voluntary Benefits Vendors Include:

- Life Insurance — Hartford
- Flexible Spending Accounts — PayFlex
- Individual Supplemental Retirement Planning (457 and 403(b)) – American Funds, Fidelity Investments, First Investors, Metropolitan Life, Midland National Life, ING/ ReliaStar Life, T-Rowe Price Trust, TIAA-CREF, VALIC, and Vanguard

Completing Your Enrollment

Active Employees (Online):

- Online open enrollment is **September 10, 2012 – October 5, 2012 (5 p.m.)**
- PIN number (for you to initiate online enrollment) mailed to your home the week of September 3, 2012
- Elect one of the CalPERS heath care plans via "iElect" (online enrollment)
- **All Active Eligible Employees and Eligible Part-Time Faculty:**
  - » You must successfully complete online enrollment to continue or initiate benefits effective January 1, 2013
  - » Online enrollment must be completed no later than 5 p.m., Friday, October 5, 2012

Retirees/Survivors Enrollees:

- **No Changes? =** No action required; CalPERS will continue your current coverage elections.
- **Changes? =** Submit all changes via paper enrollment forms to SECOVA, who can assist with your enrollment process.

COBRA Enrollees:

- **No Changes? =** No action required; CalPERS will continue your current coverage elections.
- **Changes? =** Submit all changes via paper enrollment forms to the FHDA HR/Benefits Unit, who can assist with your enrollment process.

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

2 Active Employees

Full-Time Regular and Probationary Employees, and Eligible Part-Time Faculty

Online Benefits Enrollment

Enroll Online Using www.iElect.com

Full-Time Regular and Probationary Employees, and Eligible Part-time Faculty

All benefit-eligible employees and eligible 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 for the 2013 Plan Year.

The Open Enrollment window for the 2013 Plan Year is **September 10, 2012 – October 5, 2012 (5:00 p.m.). Meet the Deadline!**

FIVE (5) STEPS TO SUCCESS!

Prior To September 10, 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 your 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 September 10, 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 2013 Plan Year benefits 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 all benefit information, confirm your benefit plan elections and coverage, and have easy access to pertinent websites.

From September 10 – October 5, 2012 (5 p.m.)

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

- Log on to ***www.iElect.com***.
- Enter Employer: FHDACCD
- 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 September 10 until October 5, 2012 (5 p.m.), 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 2013 Plan Year. **Caution:** failure to complete the election process (by

clicking the "PLEASE CONFIRM" button) will result in loss of coverage effective January 1, 2013.

CLICK IT! 

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.

Verification of Your Enrollment
You will receive an e-mail within 24 hours of enrolling that advises you that your enrollment was received and that confirms your selections.

Final Benefits Confirmation: You will receive an official benefits confirmation statement from SECOVA (FHDA's Benefits Enrollment Support Services Provider)) after the Open Enrollment period.

■ 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:

- *Adding a Spouse/Domestic Partner*
  - » Copy of your marriage license, domestic partner registration or domestic partner affidavit
  - » Copy of the spouse's/domestic partner's Social Security card
- *Adding a child dependent*
  - » Copy of the child's birth certificate or legal adoption papers
  - » Copy of the child's Social Security card.

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

THINGS YOU SHOULD KNOW

MAKING CHANGES To Your Benefits Election DURING Open Enrollment
You may make changes to your confirmed benefits election multiple times throughout Open Enrollment by logging on to **www.iElect.com** and repeating the process. **Remember** to click on the "PLEASE CONFIRM" button at the end to activate your benefits election change.

WAIT PERIOD of 24 Hours Between Changes
Once you confirm your new election by clicking the "PLEASE CONFIRM" button, the iElect system requires you to wait until the following day to access the system again for further change(s).

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 2014 (January 1 – December 31, 2014).

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" or your dependent has a "loss of coverage" event.

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 do not have 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 benefits election, 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 Benefits Fair (see enclosed information), review information online at the Benefits Unit website or contact the insurance carrier directly. Detailed plan documents and carrier contact information are available on the Benefits Unit website at **http://hr.fhda.edu/benefits.**

Cafeteria Plans (For FHDA Full-Time 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. *(Flexible spending accounts are not available to part-time faculty employees.)*

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.

Part-Time Faculty Paid Benefits Program

What benefits does the Program provide?
The Part-Time Faculty Paid Benefits Program is fully described in Article 22A of the *FA-FHDACCD Agreement,* including eligibility, medical plan coverage, and thresholds determining premium payment amounts. The program does not provide dental and vision coverage

Qualified part-time faculty employees have the option of enrolling in any one of the plans currently offered by CalPERS:

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

Brief information, including benefits, coverage limitations, deductibles, copays, and coinsurance, is contained in the *CalPERS 2013 Health Benefit Summary.* Full information is provided in the plan documents provided by the respective provider: Anthem Blue Cross for PERS Select, PERS Choice, and PERSCare; Blue Shield for Access+ and NetValue; Kaiser for Kaiser CA.

The Program provides medical coverage for the qualified part-time faculty member and his or her spouse/domestic partner and/or eligible dependent(s).

How is eligibility determined?
A part-time faculty employee must have reemployment preference, an annual load factor of .400 or more, and affirm annually that he or she does not have access to medical insurance where all or part of the premium is paid through some other source (other than Medicare). Eligibility is determined annually for the period January 1 through December 31 based upon the part-time faculty employee's load and attainment of reemployment preference during the prior academic year. For example, eligibility for benefits on January 1, 2013 is determined by the employee's assignment

during the 2011-2012 academic year. See Article 22A of the FA-FHDACCD Agreement for more details.

What does the District contribute to the cost of the monthly premium? What does the employee pay?
The CalPERS Select plan is the "basic" plan, all other plans are a "buy-up." The contribution rates have three tiers:

- employee-only;
- employee plus one;
- employee plus family.

Rates for each tier are expressed monthly, i.e., 1/12th of the employee's annual contribution.

Effective January 1, 2013, the Paid Benefits Program has three load thresholds, each with a respective District contribution to the premium cost. For employees with loads of .4 up to .499, the District is responsible for payment of forty percent (40%) of the Select monthly plan premium or the dollar equivalent under the other plan options. For employees with loads of .5 up to .599, the District is responsible for payment of fifty percent (50%) of the Select monthly plan premium or the dollar equivalent under the other plan options. For employees with loads of .6 up to .67, the District is responsible for payment of sixty percent (60%) of the Select monthly plan premium or the dollar equivalent under the other plan options. The employee is responsible for the remainder of the monthly plan premium for the coverage elected.

How does the employee pay the required monthly contribution?
Part-time faculty participating in the 2013 Plan Year will have contributions recovered in nine (9) equal monthly payroll deductions: January, February, March, April, May, June, October, November, and December of 2013. This means that the twelve months of coverage will be paid in nine equal installments deducted from the regular payroll periods. In the event the required employee monthly contribution (a) exceeds compensation in any regular pay period, or (b) the employee is not due compensation during a regular pay period, the employee has the responsibility for paying the District directly for the uncovered amount in accord with the Plan Compliance timelines and procedures.

Example:
For Plan Year 2013, part-time faulty member Roytan qualified for District-paid benefits at the 60% threshold and enrolled in the CalPERS Select Plan for employee plus one, requiring an employee monthly contribution of $417. This means the annual (12 months) rate is $5,004 ($417 x 12). The annual amount is paid in nine equal installments of $556 ($5,004 ÷ 9). Mr. Roytan will have $556 deducted (pre-tax) from his January, February, March, April, May, June, October, November, and December paychecks).

More Information
Questions should be directed to the Faculty Association (FA): phone, **650 949-7544** or e-mail, **elwellsusanne@fhda.edu**.

Employee/Retiree Monthly Contribution Rates Effective January 1 – December 31, 2013

2013 CalPERS PLAN*	Per Month Contribution
PERSCare / PERSCare-Medicare	
E	$457
E + 1	$914
E + family	$1,371
PERS Choice / PERS Choice Medicare	
E	$125
E + 1	$250
E + family	$376
PERS Select / PERS Select-Medicare	
E	$70
E + 1	$140
E + family	$210
Blue Shield Access+ / Blue Shield Access+ - Medicare	
E	$257
E + 1	$514
E + family	$771
Blue Shield NetValue / Blue Shield NetValue-Medicare	
E	$174
E + 1	$348
E + family	$522
Kaiser CA / Kaiser CA-Medicare	
E	$78
E + 1	$156
E + family	$234

Includes Dental and Vision

Part-time Faculty Monthly Contribution Rates Effective January 1 – December 31, 2013

2013 CalPERS PLAN	Per Month Contribution	Per Month Contribution	Per Month Contribution
PERSCare	**Load = .400 – .499**	**Load = .500 – .599**	**Load = .600 – .670**
E	$893	$841	$788
E + 1	$1,785	$1,681	$1,577
E + family	$2,321	$2,185	$2,050
PERS Choice			
E	$406	$354	$301
E + 1	$811	$707	$603
E + family	$1,055	$919	$784
PERS Select			
E	$313	$261	$209
E + 1	$626	$522	$417
E + family	$814	$678	$542
Blue Shield Access+			
E	$552	$500	$488
E + 1	$1,105	$1,000	$896
E + family	$1,436	$1,300	$1,165
Blue Shield NetValue			
E	$446	$394	$341
E + 1	$892	$787	$683
E + family	$1,159	$1,023	$888
Kaiser CA			
E	$392	$327	$261
E + 1	$784	$653	$523
E + family	$1,019	$849	$679

Does Not include Dental and Vision

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 of January 1, 2013 through December 31, 2013. 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):**
   $500 minimum; $2,500 maximum (Annual)

- 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 January 31, 2013.

2. **Dependent Care Account (DCA):**
   $500 minimum; $5,000 maximum (Annual)
   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 January 31, 2013.

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 2013 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 2013 Plan Year (January 1, 2013 – December 31, 2013) is March 31, 2014. Failure to incur expenses within the 2013 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 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*.

EXISTING POLICY HOLDERS will be defaulted to the same level of coverage and premium for the period of January – December 2013. 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 MAKE A CHANGE: 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**.
- If enrolling or making a change, complete both the HARTFORD Life Insurance Application and Evidence of Insurability (EOI) forms through SECOVA online enrollment by the deadline of October 5, 2012.
    - » Failure to complete both online 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 January 1, 2013. 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 twelve pay periods. 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.

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 & COBRA Enrollees

Paper Forms Benefit Enrollment

All Retirees, Surviving Spouses and COBRA Enrollees

If you are a **CURRENT ENROLLEE** in an FHDA-sponsored CalPERS Healthcare plan and want to ROLLOVER your present coverage, that is **MAKE NO CHANGES** to current coverage:

- ***You do NOT have to take any action during this Open Enrollment.***
- Your medical, dental, and vision coverage (selected medical plan and coverage for spouse/domestic partner/dependent(s)) will continue, unchanged for the 2013 Plan Year.

If you are a **NEW ENROLLEE or RE-INITIATING COVERAGE** (following a waiver) in an FHDA-sponsored CalPERS Healthcare plan **OR** you are a **CURRENT ENROLLEE and WISH TO MAKE CHANGES** to your plan and/or coverage for your spouse/domestic partner, dependent(s):

- Retirees, surviving spouses and COBRA enrollees must successfully complete their benefits enrollment using the paper forms provided by CalPERS (mailed to your home address) to continue or initiate healthcare benefits coverage for the 2013 Plan Year.

The Open Enrollment window for the 2013 Plan Year is **September 10, 2013 – October 5, 2012, 5 p.m. Meet the Deadline!**

FOUR (4) STEPS TO SUCCESS!

(Only for those who need to take action during the Open Enrollment!)

Please complete the following Four Steps to make changes to your plan and/or coverage for your spouse/domestic partner/dependent(s)

Prior To September 10, 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 September 10, 2012 – October 5, 2012, 5 p.m.

■ **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 add or initiate coverage for 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 3a (optional): Attend the Benefits Retiree Enrollment Workshop

Before completing your Open Enrollment, you are encouraged to attend the September 21, 2012 Workshop. This is an opportunity to review the CalPERS plans, speak with benefits representatives and ask questions. If you cannot attend the workshop, information on the CalPERS Healthcare Plans is available online at CalPERS **(www.calpers.ca.gov)** and the District **(hr.fhda.edu/benefits).**

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

To complete your benefits election, submit all completed forms and required documentation to SECOVA to activate your benefits election for the 2013 Plan Year. All forms and documents must be received by SECOVA (FHDA's Benefits Enrollment Support Services Provider) **not later than**
5 p.m., October 5, 2012. Failing to complete the forms and submit the required forms and documents by the deadline may result in loss of coverage effective January 1, 2013.

Recommendation #1: In order to allow the District to assist you with completion of your Open Enrollment, please send all Open Enrollment paperwork to SECOVA rather than CalPERS (as directed in the CalPERS materials sent to you). If you send your paperwork to SECOVA, the District can check to see that your enrollment and required documents have been successfully completed by the October 5 deadline; this is not possible if you send your paperwork directly to CalPERS. At the close of Open Enrollment, SECOVA will forward your paperwork to CalPERS.

Recommendation #2: 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: If you submitted your documents to SECOVA, you will receive a Confirmation Statement from SECOVA following Open Enrollment.

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 and you have submitted your materials to SECOVA, 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 2013 for the 2014 Plan Year .

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" or your dependent has a "loss of coverage" event.

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 essential to protecting your health benefit coverage.

Retirement Warrant Deductions
By completing your enrollment forms or allowing your coverage to rollover, you authorize changes to your benefits election for the 2013 Plan Year, 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 September 10 – October 5, 2012
Monday – Friday, 8 a.m. – 8 p.m.
Phone: **(866) 364-2594**
eFax: **(877) 635-4606**
E-mail: **fhda.retireebenefits@SECOVA.com**
By Mail: SECOVA
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

Electronic Funds Transfer

If you have already initiated Electronic Funds Transfer (EFT) during the April 2012 Open Enrollment

YOU DO NOT NEED TO DO ANYTHING FURTHER unless you have changed bank accounts. If you change banks, you must notify SECOVA immediately to avoid non-payment concerns.

Required to Initiate Health Benefits for the 2013 Plan Year: *Authorizing Electronic Funds Transfer*

All Retirees who wish to initiate coverage through one of the FHDA-sponsored CalPERS Health plans are required to complete and submit by October 5, 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 for the 2013 Plan Year.

(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 Change Banks?

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

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

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

How CalPERS Payments, Required Retiree Monthly Contributions, and District Reimbursements Work

How do I pay the required monthly contribution for the CalPERS plan I selected?

CalPERS will make a deduction from your STRS or PERS warrant (pension 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.

How much will CalPERS deduct from my pension check ?

There are three components that determine the CalPERS Healthcare Plan deduction from the Retiree's STRS or PERS warrant (pension check):

1. **Component 1** is the full monthly premium for the CALPERS health plan and tier (employee- only; employee plus one dependent; or employee plus family) selected.
2. **Component 2** is whether the Retiree and his or her dependent(s) are Medicare-eligible.
    - » Basic Monthly (B) applies when both the Retiree and dependent(s) are non-Medicare-eligible Retirees :
    - » Supplemental/Managed Medicare Monthly Rate (SM) when both the Retiree and dependent(s) are Medicare-eligible;
    - » Combination Monthly Rate when the Retiree is Medicare-eligible and dependent(s) are non-Medicare-eligible, or vice versa (when the Retiree is non-Medicare-eligible and dependent(s) are Medicare-eligible.
3. **Component 3** is the region in which the Retiree lives: Bay Area Region, Other Northern California Region, Out of State Region, Los Angeles Region,

Other Southern California Region and Sacramento Region. These regional rate sheets appear at the end of this chapter and are useful in clarifying how much CalPERS will deduct from your warrant.

How much of this deduction do I actually owe?
You are responsible for the Employee/Retiree monthly contribution rate for the plan and tier you selected. These rates are specified on *Employee/Retiree Monthly Contribution Rates Effective January 1, 2013 – December 31, 2013* included in this chapter.

How am I reimbursed?
The District determines the difference between the CalPERS premium deducted from the Retiree's retirement check and the Employee/Retiree monthly contribution rate for the plan and tier selected. On or about the first of the month, the District deposits this difference to the Retiree's authorized bank account.

Example A – PERS/STRS Retiree
Retiree Fox receives a STRS warrant of $3,000 monthly. He lives in the Bay Area Region, is Medicare- eligible, and selected the CalPERS Choice Plan for employee-only. The CalPERS Health Plan deduction is $325.74 from his $3,000 STRS warrant. The Employee/Retiree monthly contribution rate is $125. The District reimbursement will be $200.74 ($325.74 minus $125.00), made as a direct deposit to Mr. Fox's bank account through EFT.

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, CalPERS will bill the retiree directly.

Example B – PERS Retiree
Retiree Cook receives a PERS warrant of $1,000 monthly. She lives in the Los Angeles Area Region, is not Medicare-eligible, and selected the CalPERS Kaiser Plan for employee plus one. The CalPERS Health Plan deduction is $1,004.80. The warrant is insufficient to cover this amount; CalPERS Health Plan will deduct the amount possible, i.e., $1,000, from the PERS warrant and bill Ms. Cook for the remaining $4.80. The Employee/Retiree monthly contribution rate is $156. The District reimbursement will be $848.80 ($1,004.80 minus $156), made as a direct deposit to Ms. Cook's bank account through EFT.

Example C – STRS Retiree
Retiree Garcia receives a STRS warrant of $1,600 monthly. She lives in the Out of State Region, is not Medicare-eligible, and selected the CalPERS Choice Plan for employee plus family. The CalPERS Health Plan deduction is $1,960.95. The warrant is insufficient to cover this amount; CalPERS Health Plan will make no deduction from the STRS warrant and bill Ms. Garcia for the entire $1,960.95. The Employee/Retiree monthly contribution rate is $376. The District reimbursement will be $1,584.95 ($1,960.95 minus $376), made as a direct deposit to Ms. Garcia's bank account through EFT.

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 Medicare Part B premium reimbursements only, by October 5, 2012. Survivors who are not PERS/STRS annuitants must pre-pay quarterly in accordance with current procedures.

Note: Survivors are not entitled to any CalPERS medical premium reimbursement.

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: **(877) 635-4606**
E-mail: **fhda.retireebenefits@SECOVA.com**

Employee/Retiree Monthly Contribution Rates Effective January 1 – December 31, 2013	
2013 CalPERS PLAN*	**Per Month Contribution**
PERSCare / PERSCare — Medicare	
E	$457
E + 1	$914
E + family	$1,371
PERS Choice / PERS Choice — Medicare	
E	$125
E + 1	$250
E + family	$376
PERS Select / PERS Select — Medicare	
E	$70
E + 1	$140
E + family	$210
Blue Shield Access+ / Blue Shield Access+ — Medicare	
E	$257
E + 1	$514
E + family	$771
Blue Shield NetValue / Blue Shield NetValue — Medicare	
E	$174
E + 1	$348
E + family	$522
Kaiser CA / Kaiser CA — Medicare	
E	$78
E + 1	$156
E + family	$234
***Includes Dental and Medical**	

Foothill-De Anza Community College District
Surviving Spouse Rates — 2013

Medical and Dental/Vision/EAP

				SURVIVING SPOUSE RATES
PERSCare	**CalPERS Rates**	**Dental/Vision**	**EAP**	**Medical/Dental/Vision/EAP**
Surviving Spouse without Medicare	$1,083.11	$85.29	$3.19	$1,171.59
Surviving Spouse with Medicare	$370.43	$85.29	$3.19	$458.91
PERS Choice	**CalPERS Rates**	**Dental/Vision**	**EAP**	**Medical/Dental/Vision/EAP**
Surviving Spouse without Medicare	$667.03	$85.29	$3.19	$755.51
Surviving Spouse with Medicare	$325.74	$85.29	$3.19	$414.22
PERS Select	**CalPERS Rates**	**Dental/Vision**	**EAP**	**Medical/Dental/Vision/EAP**
Surviving Spouse without Medicare	$487.20	$85.29	$3.19	$575.68
Surviving Spouse with Medicare	$325.74	$85.29	$3.19	$414.22
Blue Shield Access+	**CalPERS Rates**	**Dental/Vision**	**EAP**	**Medical/Dental/Vision/EAP**
Surviving Spouse without Medicare	$784.63	$85.29	$3.19	$873.11
Surviving Spouse with Medicare	$261.32	$85.29	$3.19	$349.80
Blue Shield NetValue	**CalPERS Rates**	**Dental/Vision**	**EAP**	**Medical/Dental/Vision/EAP**
Surviving Spouse without Medicare	$670.21	$85.29	$3.19	$758.69
Surviving Spouse with Medicare	$261.32	$85.29	$3.19	$349.80
Kaiser	**CalPERS Rates**	**Dental/Vision**	**EAP**	**Medical/Dental/Vision/EAP**
Surviving Spouse without Medicare	$668.63	$85.29	$3.19	$757.11
Surviving Spouse with Medicare	$288.37	$85.29	$3.19	$376.85

Note: Medical monthly premium is collected by CalPERS. Dental/Vision/EAP quarterly premium are offset against your EFT account set up through SECOVA on behalf of FHDA

Foothill-De Anza Community College District
COBRA Rates - 2013

Medical and EAP/Dental/Vision

Medical Only —CalPERS Monthly Premium

	Single	Two Party	Family
Kaiser HMO	682.00	1,364.01	1,773.21
Blue Shield NetValue HMO	683.61	1,367.23	1,777.40
Blue Shield Access+ HMO	800.32	1,600.65	2,080.84
PERS Select PPO	496.94	993.89	1,292.05
PERS Choice PPO	680.37	1,360.74	1,768.97
PERSCare PPO	1,104.77	2,209.54	2,872.41

*EAP/Dental/Vision — Monthly Premium

	Single	Two Party	Family
EAP	3.25	3.25	3.25
Dental & Vision	87.00	173.99	243.59

Combined Medical/EAP/Dental/Vision — Monthly Premium

	Single	Two Party	Family
Kaiser HMO	772.25	1,541.25	2,020.05
Blue Shield NetValue HMO	773.86	1,544.47	2,024.24
Blue Shield Access+ HMO	890.57	1,777.89	2,327.68
PERS Select PPO	587.19	1,171.13	1,538.89
PERS Choice PPO	770.62	1,537.99	2,015.81
PERSCare PPO	1,195.02	2,386.79	3,119.25

Note: EAP/Dental/Vision care are not available to PT Faculty COBRA enrollees

4 Annual Health Plan Notices

Legal Disclosures, Notifications

Foothill-De Anza Community College District
HEALTH PLAN NOTICES
2013

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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 from Foothill-De Anza Community College District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Foothill De-Anza Community College School 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 School 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 School 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 School 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 School District changes. You also may request a copy.

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: July 16, 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. 5/13/11

IMPORTANT NOTICE
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.

T**his 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 School 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 disenrollments, 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

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: July 16, 2012

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.

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.)

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 health care coverages subject to the HIPAA portability rules.***

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 general 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

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) 234-5141 (outside the continental U.S.)

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

Kaiser Permanente
Member Services (800) 464-4000

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, 2012. You should contact your State for further information on eligibility.

ALABAMA — Medicaid	**COLORADO — Medicaid**
Website: http://www.medicaid.alabama.gov	Medicaid Website: http://www.colorado.gov/
Phone: 1-855-692-5447	Medicaid Phone (In state): 1-800-866-3513
	Medicaid Phone (Out of state): 1-800-221-3943
ALASKA — Medicaid	**FLORIDA — Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/	Website: https://www.flmedicaidtplrecovery.com/
Phone (Outside Anchorage): 1-888-318-8890	Phone: 1-877-357-3268
Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**GEORGIA — Medicaid**
Website: http://www.azahcccs.gov/applicants	Website: http://dch.georgia.gov/
Phone (Outside of Maricopa County): 1-877-764-5437	Click on Programs, then Medicaid
Phone (Maricopa County): 602-417-5437	Phone: 1-800-869-1150

IDAHO — Medicaid and CHIP	**MONTANA — Medicaid**
Medicaid Website: www.accesstohealthinsurance.idaho.gov	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Medicaid Phone: 1-800-926-2588	Phone: 1-800-694-3084
CHIP Website: www.medicaid.idaho.gov	
CHIP Phone: 1-800-926-2588	
INDIANA — Medicaid	**NEBRASKA — Medicaid**
Website: http://www.in.gov/fssa	Website: http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx
Phone: 1-800-889-9948	Phone: 1-877-255-3092
IOWA — Medicaid	**NEVADA — Medicaid**
Website: www.dhs.state.ia.us/hipp/	Medicaid Website: http://dwss.nv.gov/
Phone: 1-888-346-9562	Medicaid Phone: 1-800-992-0900
KANSAS — Medicaid	**NEW HAMPSHIRE — Medicaid**
Website: http://www.kdheks.gov/hcf/	Website: www.dhhs.nh.gov/ombp/index.htm
Phone: 1-800-792-4884	Phone: 603-271-5218
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
LOUISIANA — Medicaid	CHIP Website: http://www.njfamilycare.org/index.html
Website: http://www.lahipp.dhh.louisiana.gov	CHIP Phone: 1-800-701-0710
Phone: 1-888-695-2447	
MAINE — Medicaid	**NEW YORK — Medicaid**
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html	Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-572-3839	Phone: 1-800-541-2831
MASSACHUSETTS — Medicaid and CHIP	**NORTH CAROLINA — Medicaid and CHIP**
Website: http://www.mass.gov/MassHealth	Website: http://www.ncdhhs.gov/dma
Phone: 1-800-462-1120	Phone: 919-855-4100
MINNESOTA — Medicaid	**NORTH DAKOTA — Medicaid**
Website: http://www.dhs.state.mn.us/	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Click on Health Care, then Medical Assistance	Phone: 1-800-755-2604
Phone: 1-800-657-3629	
MISSOURI — Medicaid	**UTAH — Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	Website: http://health.utah.gov/upp
Phone: 573-751-2005	Phone: 1-866-435-7414

OKLAHOMA — Medicaid and CHIP	**VERMONT– Medicaid**
Website: http://www.insureoklahoma.org	Website: http://www.greenmountaincare.org/
Phone: 1-888-365-3742	Phone: 1-800-250-8427
OREGON — Medicaid and CHIP	**VIRGINIA — Medicaid and CHIP**
Website: http://www.oregonhealthykids.gov	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm
http://www.hijossaludablesoregon.gov	Medicaid Phone: 1-800-432-5924
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/hipp	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-692-7462	Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND — Medicaid	**WEST VIRGINIA — Medicaid**
Website: www.ohhs.ri.gov	Website: www.dhhr.wv.gov/bms/
Phone: 401-462-5300	Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH CAROLINA — Medicaid	**WISCONSIN — Medicaid**
Website: http://www.scdhhs.gov	Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-888-549-0820	Phone: 1-800-362-3002
SOUTH DAKOTA - Medicaid	**WYOMING — Medicaid**
Website: http://dss.sd.gov	Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 1-888-828-0059	Phone: 307-777-7531
TEXAS — Medicaid	
Website: https://www.gethipptexas.com/	
Phone: 1-800-440-0493	

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 Services
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

OMB Control Number 1210-0137 (expires 09/30/2013)
Revised 3/21/12

5 General Information

Domestic Partner of Active Employee Imputed Income

Foothill-De Anza Community College District Monthly Imputed Income Rates — 2013		
Domestic Partner of Active Employee	**Medical/Dental/Vision**	**Medical Only**
PERSCare	**PERSCare**	**PERSCare**
	Medical/Dental/Vision	**Medical Only**
	With EAP, Dep. Life	With EAP, Dep. Life
	Imputed Income	***Imputed Income***
Same-Sex DP Only w/o Medicare	$713.40	$628.11
Same-Sex DP Only with Medicare	$713.40	$628.11
Same-Sex Domestic Partner's CHILD ONLY	$713.40	$628.11
Same-Sex DP w/o Medicare, Plus DP Child	$978.23	$824.71
Same-Sex DP w/o Medicare, Plus DP Children	$978.23	$824.71
Same-Sex DP with Medicare, Plus DP Child	$978.23	$824.71
Same-Sex DP with Medicare, Plus DP Children	$978.23	$824.71
Same-Sex Domestic Partner's CHILDREN ONLY	$978.23	$824.71
PERS Choice	**PERS Choice**	**PERS Choice**
	Medical/Dental/Vision	**Medical Only**
	With EAP, Dep. Life	With EAP, Dep. Life
	Imputed Income	***Imputed Income***
Same-Sex DP Only w/o Medicare	$629.32	$544.03
Same-Sex DP Only with Medicare	$629.32	$544.03
Same-Sex Domestic Partner's CHILD ONLY	$629.32	$544.03
Same-Sex DP w/o Medicare, Plus DP Child	$975.50	$821.98
Same-Sex DP w/o Medicare, Plus DP Children	$975.50	$821.98
Same-Sex DP with Medicare, Plus DP Child	$975.50	$821.98
Same-Sex DP with Medicare, Plus DP Children	$975.50	$821.98
Same-Sex Domestic Partner's CHILDREN ONLY	$975.50	$821.98

Notes: The definition of Children includes Certified Disabled Dependents over the age of 26

Domestic Partner of Active Employee Imputed Income

Foothill-De Anza Community College District Monthly Imputed Income Rates — 2013		
Domestic Partner of Active Employee	**Medical/Dental/Vision**	**Medical Only**
PERS Select	**PERS Select**	**PERS Select**
	Medical/Dental/Vision	**Medical Only**
	With EAP, Dep. Life	With EAP, Dep. Life
	Imputed Income	***Imputed Income***
Same-Sex DP Only w/o Medicare	$504.49	$419.20
Same-Sex DP Only with Medicare	$504.49	$419.20
Same-Sex Domestic Partner's CHILD ONLY	$504.49	$419.20
Same-Sex DP w/o Medicare, Plus DP Child	$798.77	$645.25
Same-Sex DP w/o Medicare, Plus DP Children	$798.77	$645.25
Same-Sex DP with Medicare, Plus DP Child	$798.77	$645.25
Same-Sex DP with Medicare, Plus DP Children	$798.77	$645.25
Same-Sex Domestic Partner's CHILDREN ONLY	$798.77	$645.25
Blue Shield Access+	**Blue Shield Access+**	**Blue Shield Access+**
	Medical/Dental/Vision	**Medical Only**
	With EAP, Dep. Life	With EAP, Dep. Life
	Imputed Income	***Imputed Income***
Same-Sex DP Only w/o Medicare	$614.92	$529.63
Same-Sex DP Only with Medicare	$614.92	$529.63
Same-Sex Domestic Partner's CHILD ONLY	$614.92	$529.63
Same-Sex DP w/o Medicare, Plus DP Child	$900.66	$747.14
Same-Sex DP w/o Medicare, Plus DP Children	$900.66	$747.14
Same-Sex DP with Medicare, Plus DP Child	$900.66	$747.14
Same-Sex DP with Medicare, Plus DP Children	$900.66	$747.14
Same-Sex Domestic Partner's CHILDREN ONLY	$900.66	$747.14

Notes: The definition of Children includes Certified Disabled Dependents over the age of 26

Domestic Partner of Active Employee Imputed Income

Foothill-De Anza Community College District Monthly Imputed Income Rates — 2013		
Domestic Partner of Active Employee	**Medical/Dental/Vision**	**Medical Only**
Blue Shield NetValue	**Blue Shield NetValue**	**Blue Shield NetValue**
	Medical/Dental/Vision	**Medical Only**
	With EAP, Dep. Life	With EAP, Dep. Life
	Imputed Income	***Imputed Income***
Same-Sex DP Only w/o Medicare	$583.50	$498.21
Same-Sex DP Only with Medicare	$583.50	$498.21
Same-Sex Domestic Partner's CHILD ONLY	$583.50	$498.21
Same-Sex DP w/o Medicare, Plus DP Child	$883.59	$730.07
Same-Sex DP w/o Medicare, Plus DP Children	$883.59	$730.07
Same-Sex DP with Medicare, Plus DP Child	$883.59	$730.07
Same-Sex DP with Medicare, Plus DP Children	$883.59	$730.07
Same-Sex Domestic Partner's CHILDREN ONLY	$883.59	$730.07
Kaiser	**Kaiser**	**Kaiser**
	Medical/Dental/Vision	**Medical Only**
	With EAP, Dep. Life	With EAP, Dep. Life
	Imputed Income	***Imputed Income***
Same-Sex DP Only w/o Medicare	$677.92	$592.63
Same-Sex DP Only with Medicare	$677.92	$592.63
Same-Sex Domestic Partner's CHILD ONLY	$677.92	$592.63
Same-Sex DP w/o Medicare, Plus DP Child	$1,073.06	$919.54
Same-Sex DP w/o Medicare, Plus DP Children	$1,073.06	$919.54
Same-Sex DP with Medicare, Plus DP Child	$1,073.06	$919.54
Same-Sex DP with Medicare, Plus DP Children	$1,073.06	$919.54
Same-Sex Domestic Partner's CHILDREN ONLY	$1,073.06	$919.54

Notes: The definition of Children includes Certified Disabled Dependents over the age of 26

Domestic Partner of Part-Time Faculty Imputed Income — Medical Only

Foothill-De Anza Community College District Monthly Imputed Income Rates — 2013

Domestic Partner of Part-Time Faculty — Medical Only

PERSCare Medical Only	**Load: .60 to .67**	**Load: .50 to .59**	**Load: .40 to .499**
	Imputed Income	***Imputed Income***	***Imputed Income***
Same-Sex DP Only w/o Medicare	$294.11	$243.11	$191.11
Same-Sex DP Only with Medicare	$294.11	$243.11	$191.11
Same-Sex Domestic Partner's CHILD ONLY	$294.11	$243.11	$191.11
Same-Sex DP w/o Medicare, Plus DP Child	$470.98	$388.98	$304.98
Same-Sex DP w/o Medicare, Plus DP Children	$470.98	$388.98	$304.98
Same-Sex DP with Medicare, Plus DP Child	$470.98	$388.98	$304.98
Same-Sex DP with Medicare, Plus DP Children	$470.98	$388.98	$304.98
Same-Sex Domestic Partner's CHILDREN ONLY	$470.98	$388.98	$304.98

PERS Choice Medical Only	**Load: .60 to .67**	**Load: .50 to .59**	**Load: .40 to .499**
	Imputed Income	***Imputed Income***	***Imputed Income***
Same-Sex DP Only w/o Medicare	$365.03	$314.03	$262.03
Same-Sex DP Only with Medicare	$365.03	$314.03	$262.03
Same-Sex Domestic Partner's CHILD ONLY	$365.03	$314.03	$262.03
Same-Sex DP w/o Medicare, Plus DP Child	$584.25	$502.25	$418.25
Same-Sex DP w/o Medicare, Plus DP Children	$584.25	$502.25	$418.25
Same-Sex DP with Medicare, Plus DP Child	$584.25	$502.25	$418.25
Same-Sex DP with Medicare, Plus DP Children	$584.25	$502.25	$418.25
Same-Sex Domestic Partner's CHILDREN ONLY	$584.25	$502.25	$418.25

PERS Select Medical Only	**Load: .60 to .67**	**Load: .50 to .59**	**Load: .40 to .499**
	Imputed Income	***Imputed Income***	***Imputed Income***
Same-Sex DP Only w/o Medicare	$279.20	$226.20	$174.20
Same-Sex DP Only with Medicare	$279.20	$226.20	$174.20
Same-Sex Domestic Partner's CHILD ONLY	$279.20	$226.20	$174.20
Same-Sex DP w/o Medicare, Plus DP Child	$446.52	$362.52	$278.52
Same-Sex DP w/o Medicare, Plus DP Children	$446.52	$362.52	$278.52
Same-Sex DP with Medicare, Plus DP Child	$446.52	$362.52	$278.52
Same-Sex DP with Medicare, Plus DP Children	$446.52	$362.52	$278.52
Same-Sex Domestic Partner's CHILDREN ONLY	$446.52	$362.52	$278.52

Notes: The definition of Children includes Certified Disabled Dependents over the age of 26

Domestic Partner of Part Time Faculty — Medical Only

Foothill-De Anza Community College District Monthly Imputed Income Rates — 2013

Domestic Partner of Part-Time Faculty — Medical Only

Blue Shield Access+ Medical Only	**Load: .60 to .67**	**Load: .50 to .59**	**Load: .40 to .499**
	Imputed Income	***Imputed Income***	***Imputed Income***
Same-Sex DP Only w/o Medicare	$336.63	$284.63	$231.63
Same-Sex DP Only with Medicare	$336.63	$284.63	$231.63
Same-Sex Domestic Partner's CHILD ONLY	$336.63	$284.63	$231.63
Same-Sex DP w/o Medicare, Plus DP Child	$538.41	$455.41	$371.41
Same-Sex DP w/o Medicare, Plus DP Children	$538.41	$455.41	$371.41
Same-Sex DP with Medicare, Plus DP Child	$538.41	$455.41	$371.41
Same-Sex DP with Medicare, Plus DP Children	$538.41	$455.41	$371.41
Same-Sex Domestic Partner's CHILDREN ONLY	$538.41	$455.41	$371.41

Blue Shield NetValue Medical Only	**Load: .60 to .67**	**Load: .50 to .59**	**Load: .40 to .499**
	Imputed Income	***Imputed Income***	***Imputed Income***
Same-Sex DP Only w/o Medicare	$328.21	$277.21	$224.21
Same-Sex DP Only with Medicare	$328.21	$277.21	$224.21
Same-Sex Domestic Partner's CHILD ONLY	$328.21	$277.21	$224.21
Same-Sex DP w/o Medicare, Plus DP Child	$525.34	$443.34	$359.34
Same-Sex DP w/o Medicare, Plus DP Children	$525.34	$443.34	$359.34
Same-Sex DP with Medicare, Plus DP Child	$525.34	$443.34	$359.34
Same-Sex DP with Medicare, Plus DP Children	$525.34	$443.34	$359.34
Same-Sex Domestic Partner's CHILDREN ONLY	$525.34	$443.34	$359.34

Kaiser Medical Only	**Load: .60 to .67**	**Load: .50 to .59**	**Load: .40 to .499**
	Imputed Income	***Imputed Income***	***Imputed Income***
Same-Sex DP Only w/o Medicare	$406.63	$342.63	$276.63
Same-Sex DP Only with Medicare	$406.63	$342.63	$276.63
Same-Sex Domestic Partner's CHILD ONLY	$406.63	$342.63	$276.63
Same-Sex DP w/o Medicare, Plus DP Child	$651.81	$547.81	$442.81
Same-Sex DP w/o Medicare, Plus DP Children	$651.81	$547.81	$442.81
Same-Sex DP with Medicare, Plus DP Child	$651.81	$547.81	$442.81
Same-Sex DP with Medicare, Plus DP Children	$651.81	$547.81	$442.81
Same-Sex Domestic Partner's CHILDREN ONLY	$651.81	$547.81	$442.81

Notes: The definition of Children includes Certified Disabled Dependents over the age of 26

Domestic Partner of Retiree — Medical/Dental/Vision

Foothill-De Anza Community College District Monthly Imputed Income Rates — 2013

Domestic Partner of Retiree — Without and With Medicare

PERSCare Medical/Dental/Vision	***Retiree Without Medicare***	***Retiree With Medicare***
	Imputed Income	***Imputed Income***
Same-Sex DP Only w/o Medicare	$713.40	$713.40
Same-Sex DP Only with Medicare	$0.72	$0.72
Same-Sex Domestic Partner's CHILD ONLY	$713.40	$713.40
Same-Sex DP w/o Medicare, Plus DP Child	$908.27	$908.27
Same-Sex DP w/o Medicare, Plus DP Children	$908.27	$908.27
Same-Sex DP with Medicare, Plus DP Child	$263.82	$263.82
Same-Sex DP with Medicare, Plus DP Children	$263.82	$263.82
Same-Sex Domestic Partner's CHILDREN ONLY	$976.50	$976.50

PERS Choice Medical/Dental/Vision	***Retiree Without Medicare***	***Retiree With Medicare***
	Imputed Income	***Imputed Income***
Same-Sex DP Only w/o Medicare	$629.32	$629.32
Same-Sex DP Only with Medicare	$288.03	$288.03
Same-Sex Domestic Partner's CHILD ONLY	$629.32	$629.32
Same-Sex DP w/o Medicare, Plus DP Child	$905.54	$905.54
Same-Sex DP w/o Medicare, Plus DP Children	$905.54	$905.54
Same-Sex DP with Medicare, Plus DP Child	$632.48	$632.48
Same-Sex DP with Medicare, Plus DP Children	$632.48	$632.48
Same-Sex Domestic Partner's CHILDREN ONLY	$973.77	$973.77

PERS Select Medical/Dental/Vision	***Retiree Without Medicare***	***Retiree With Medicare***
	Imputed Income	***Imputed Income***
Same-Sex DP Only w/o Medicare	$504.49	$504.49
Same-Sex DP Only with Medicare	$343.03	$343.03
Same-Sex Domestic Partner's CHILD ONLY	$504.49	$504.49
Same-Sex DP w/o Medicare, Plus DP Child	$728.81	$728.81
Same-Sex DP w/o Medicare, Plus DP Children	$728.81	$728.81
Same-Sex DP with Medicare, Plus DP Child	$635.58	$635.58
Same-Sex DP with Medicare, Plus DP Children	$635.58	$635.58
Same-Sex Domestic Partner's CHILDREN ONLY	$797.04	$797.04

Note: The definition of Children includes Certified Disabled Dependents over the age of 26

Domestic Partner of Retiree — Medical/Dental/Vision

Foothill-De Anza Community College District Monthly Imputed Income Rates — 2013

Domestic Partner of Retiree — Without and With Medicare

Blue Shield Access+ Medical/Dental/Vision	***Retiree Without Medicare***	***Retiree With Medicare***
	Imputed Income	***Imputed Income***
Same-Sex DP Only w/o Medicare	$614.92	$614.92
Same-Sex DP Only with Medicare	$91.61	$91.61
Same-Sex Domestic Partner's CHILD ONLY	$614.92	$614.92
Same-Sex DP w/o Medicare, Plus DP Child	$830.70	$830.70
Same-Sex DP w/o Medicare, Plus DP Children	$830.70	$830.70
Same-Sex DP with Medicare, Plus DP Child	$375.62	$375.62
Same-Sex DP with Medicare, Plus DP Children	$375.62	$375.62
Same-Sex Domestic Partner's CHILDREN ONLY	$898.93	$898.93

Blue Shield NetValue Medical/Dental/Vision	**Retiree Without Medicare**	**Retiree With Medicare**
	Imputed Income	**Imputed Income**
Same-Sex DP Only w/o Medicare	$583.50	$583.50
Same-Sex DP Only with Medicare	$174.61	$174.61
Same-Sex Domestic Partner's CHILD ONLY	$583.50	$583.50
Same-Sex DP w/o Medicare, Plus DP Child	$813.63	$813.63
Same-Sex DP w/o Medicare, Plus DP Children	$813.63	$813.63
Same-Sex DP with Medicare, Plus DP Child	$472.97	$472.97
Same-Sex DP with Medicare, Plus DP Children	$472.97	$472.97
Same-Sex Domestic Partner's CHILDREN ONLY	$881.86	$881.86

Kaiser Medical/Dental/Vision	***Retiree Without Medicare***	***Retiree With Medicare***
	Imputed Income	***Imputed Income***
Same-Sex DP Only w/o Medicare	$677.92	$677.92
Same-Sex DP Only with Medicare	$297.66	$297.66
Same-Sex Domestic Partner's CHILD ONLY	$677.92	$677.92
Same-Sex DP w/o Medicare, Plus DP Child	$1,003.10	$1,003.10
Same-Sex DP w/o Medicare, Plus DP Children	$1,003.10	$1,003.10
Same-Sex DP with Medicare, Plus DP Child	$691.07	$691.07
Same-Sex DP with Medicare, Plus DP Children	$691.07	$691.07
Same-Sex Domestic Partner's CHILDREN ONLY	$1,071.33	$1,071.33

Note: The definition of Children includes Certified Disabled Dependents over the age of 26

6 Additional Forms and Documents

The following forms are available for you to copy and use, unless marked "Sample

Health Benefit Enrollment Change — Retirees

Health Benefit Initial 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 Power of Attorney

CVS Caremark Rx Guide

CVS Caremark Rx Mail Order

Medical Report — Disabled Dependent

Questionnaire — Disabled Dependent

Change of Address (FHDA) — Active Employees

Change of Address (FHDA) — Retirees

Change of Address — CalPERS

(All CalPERS forms also available online at **www.calpers.ca.gov**)

Health Benefits Plan Enrollment for Retirees

888 CalPERS (or **888**-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240 • FAX (916) 795-1313

For Retirees only. (Active employees - contact your Personnel Office.)

To save time, complete this form before you request changes over the phone.

Section 1 Type of Change

Check the type of change you are making.

- ☐ Change My Health Plan
- ☐ Enroll in a Health Plan. (Complete all sections.)
- ☐ Add Eligible Dependents to My Health Plan.
  (Complete Retiree Information, Dependent Information and Retiree Signature.)

Section 2 Retiree Information

Be sure to include the name of the agency from which you retired.

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

Birthdate (mm/dd/yyyy) | Gender | Daytime Phone | Evening Phone

If you are enrolled in Medicare, please send a copy of your Medicare card.

Address | County (residence)

City | State | ZIP

Retirement Date (mm/dd/yyyy) | Name of Former Employer

Section 3 Health Plan

Before requesting a plan change, verify that the doctor you want is contracted with the health plan and is accepting new patients. If not, you will need to find another doctor who contracts with the new plan.

Name of New Health Plan | Name of Doctor/Medical Group (include ID#s, if known)

Section 4 Dependent Information

All dependents currently enrolled on your health plan will remain on your plan.

Dependent Name | Social Security Number | Birthdate (mm/dd/yyyy)

Relationship | Gender | Doctor or Medical Group

List only the dependents you are adding. If you have more than 3 dependents, please include on a separate page.

Dependent Name | Social Security Number | Birthdate (mm/dd/yyyy)

Relationship | Gender | Doctor or Medical Group

Dependent Name | Social Security Number | Birthdate (mm/dd/yyyy)

Relationship | Gender | Doctor or Medical Group

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

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: **4628924879** **Foothill-De Anza Community College District**	**Group/Bargaining Unit:**	**Retirement System:**

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:
❑ January 1, 2013

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

*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 AUTHORIZE DEDUCTIONS TO BE MADE FROM MY RETIREMENT ALLOWANCE TO COVER MY SHARE OF THE COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF ALL DEPENDENTS LISTED ABOVE ARE ELIGIBLE FAMILY MEMBERS AS DEFINED IN THE PUBLIC EMPLOYEES MEDICAL AND HOSPITAL CARE ACT.

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

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	☐ EMPLOYMENT SEPARATION/TIMEBASE REDUCTION		FROM 01
☐ CHANGE	☐ DIVORCE/LEGAL SEPARATION		
	☐ CHILD CEASES TO BE A DEPENDENT		
	☐ DEATH OF AN EMPLOYEE/RETIREE		
	☐ DEPENDENT CONTINUATION - ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE		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		SELF
	(FIRST) (MI) (LAST)		
	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

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

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**

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).

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.

NUBAAG

CVS CAREMARK

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

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CVS CAREMARK

RESET FORM PRINT FORM

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 fold here

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)_____

* WEB *

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

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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 *

Please fold here ↑ * WEB *

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:_____ **SOCIAL SECURITY NUMBER (SSN)**_____ **ADDRESS:**_____ **TELEPHONE ( )**_____	**NAME:**_____ **SSN**_____ **ADDRESS:**_____ **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
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FAX (916) 795-1277

MEMBER QUESTIONNAIRE for the CalPERS DISABLED DEPENDENT BENEFIT

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

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

FOOTHILL-DE ANZA
Community College District

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		

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: (_____) _____

FOOTHILL-DE ANZA
Community College District