FAQs
THE NEW CalPERS HEALTH PLANS

Disclaimer: The information included herein is provided as a general guide only. Health insurance plans, coverage and applicable benefits shall be provided in accordance with the provisions of the applicable plans and contracts affecting covered employees and retirees. In the event of a conflict, applicable contracts and plan documents shall prevail.

SECTION 1: RETIREES

1.1 *Open Enrollment:* If I do nothing during this Open Enrollment, will the District enroll me by default into a plan similar to my current plan (e.g., enroll me into Kaiser if I currently have Kaiser coverage)?

No. During Open Enrollment, retirees must make an election into one of the six CalPERS plans to get healthcare coverage effective July 1, 2012 for six months. If a retiree does nothing then he/she will have no District-sponsored healthcare from July 1 to December 31, 2012.

1.2 *Retired Spouse/Domestic Partner of Active Employee and Medicare:*

a. Must the over-65 retired (non-district) spouse or domestic partner of an active employee enroll in Medicare Part A and Medicare Part B when included as a dependent on the active employee's health coverage?

Spouse (opposite sex):

- Coverage—for the retired spouse of an active employee, District coverage is primary, so the spouse is on the Active Plan.
- Medicare Part A Enrollment—a retired spouse is advised to enroll in Medicare Part A upon reaching Medicare-eligibility status (typically, at age 65).
- Medicare Part B Enrollment—a retired spouse delays enrollment in Medicare Part B while covered under the active employee's plan. Upon the active employee's retirement, the spouse would then enroll in Medicare Part B.

Domestic Partner (registered domestic partner/same-sex married spouse):

- Coverage—for the retired domestic partner of an active employee, District coverage is primary so the domestic partner is covered on the Active Plan.

- Medicare Part A Enrollment—a retired domestic partner is advised to enroll in Medicare Part A upon reaching Medicare eligibility status (typically, at age 65).
- Medicate Part B Enrollment—although not recommended, the domestic partner may delay enrollment in Medicare Part B and maintain coverage under the active employee's plan. However, to avoid penalties that may be imposed by CMS (Centers for Medicare and Medicaid Services) if the retired domestic partner elects to enroll in Part B at a later date, it is recommended that the retired domestic partner enroll in Medicare Part B at the time he or she becomes eligible.

b. Does the District reimburse the spouse/domestic partner of a pre-1997active employee for the cost of Part B if the active employee is a pre-1997 hire?

The District provides reimbursement for the cost of Part B for a pre-1997 employee in accordance with the applicable union contract at the time the eligible pre-1997 active employee becomes a retiree. Currently, the District reimburses the cost of Medicare Part B for a pre-1997 retiree and his or her spouse/domestic partner.

1.3 *Surviving Spouse/Domestic Partner of Pre-1997 Retired Employee:* What is the continuation of benefits rate for a surviving spouse of a pre-1997 retired employee?

An eligible surviving spouse/domestic partner pays the premium rate for the plan selected. If the eligible surviving spouse/domestic partner is Medicare-eligible, he or she pays the premium rate for the Medicare supplemental plan selected.

1.4 *Post-1997 Retired Employee Vesting for CalPERS:* Is there a vesting threshold for post-1997 retired employees to enroll in coverage under CalPERS?

There is no "vesting schedule" *per se*. To qualify for continued CalPERS coverage, the retiree must, within 120 of separation from the District, retire and be receiving a retirement warrant from a state qualified retirement plan, such as CalPERS, CalSTRS, or another state recognized qualified retirement plan.

However, a 15 or more year vesting threshold does apply when determining whether the retiree will qualify for a District monthly contribution under the District's post-1997 retired employee "Bridge Program" which helps offset the retiree's cost of health insurance benefits. The Program covers eligible retirees between the age of 55 and Medicare-eligibility at age 65 and applies to the employee and his or her spouse/domestic partner.

Except for the "Bridge Program" described above, the District makes no contribution toward the cost of post-1997 retiree coverage under CalPERS. (*See FAQ 1.7 below for more information about efforts to address the cost of continuation of coverage after age 65.)*

1.5 *Post-1997 Retired Employee Family Coverage:* May a post-1997 retiree cover a spouse/child under CalPERS?

Yes, assuming the retiree meets the CalPERS eligibility requirements for continued coverage, the retiree may cover an eligible dependent on his/her CalPERS health plan. Unless the retiree is eligible for the Bridge Program, the District makes no contribution toward the cost of post-1997 coverage under CalPERS for the retiree and his or her dependents.

1.6 *Post-1997/Over Age 65 Benefit Rates:* What rate does a post-1997/over age 65 retiree pay for continuation of benefits?

The post-1997/over age 65 retiree should enroll in Medicate Part A, purchase Medicare Part B (not reimbursed by the District) and then enroll in one of the CalPERS Medicare supplement plans. The rate will be the Medicare Supplemental Plan Rate as published by CalPERS for the Medicare supplement plan selected.

1.7 *Post-1997/Over Age 65 Fund:* What is the rationale and the purpose of the new Post-1997/Over Age 65 Fund and the $2/$4/$6 contributions? How does this affect the Post-1997 Retired Employee Bridge Program?

The Post-1997/Over Age 65 Fund is intended to address the cost of continuation of benefits for post-1997 retired employees after becoming Medicare-eligible. Details as to how this Fund will work are yet to be determined; more information will be provided at a later date. This Fund will have no effect on the Post-1997 Retired Employee Bridge program (which

provides a District monthly contribution after 15 years of vesting, up until age 65/Medicare eligibility); this benefit remains unchanged.

1.8 *Communication to Retirees:* Is there a mechanism in place to notify retirees early (and often) about open enrollment dates to address concerns about traveling, or being away for other reasons, and missing an enrollment?

During this transition, several communications will be sent to advise retirees of open enrollment dates. Following this initial transition the Open Enrollment period will be set by CalPERS and will be conducting annually on or about the same dates. Regular communications will be sent to retirees prior to Open Enrollment.

1.9 *Current Retiree EFT (Electronic Funds Transfer) Processes:* Many retirees now have their monthly health care contribution paid as an automatic electronic fund transfer. How is this process stopped now that the monthly contributions will come from their retirement warrants?

Current automatic electronic fund transfers will cease as of June 30, 2012 (with some exception for accounts in arrears) when the District's contract with UHC direct billing expires. The retiree does not have to take any action to terminate these transfers.

1.10 *Retiree Warrant Deductions—Billings and Reimbursements:*

a. How do retirees pay their required monthly contribution?

Every month, CalPERS Health will deduct the full premium for the retiree's selected plan from the retiree's PERS or STRS warrant. In almost all cases, this deduction will exceed the negotiated retiree monthly contribution required for the selected plan. Therefore, every month, the District will reimburse the difference to the retiree via an electronic fund transfer to the retiree's EFT account.

b. What happens when a retiree's monthly warrant is insufficient to cover the required monthly CalPERS deduction (the full plan premium minus a dollar)?

If the retiree receives a *monthly PERS warrant*, CalPERS will deduct the amount possible from the warrant and then bill the difference to the retiree. If, however, the retiree receives a *monthly STRS warrant*, CalPERS

will take nothing from the warrant and will bill the entire monthly contribution to the retiree. .

c. So both the District and CalPERS will transfer funds in and out of the retiree's designated EFT account?

The District will transfer funds into/out of the Retiree's EFT account. Our understanding is that at this time CalPERS does not yet have EFT processing set up but may make it available in the future. Retirees must send a completed form to SECOVA to authorize District electronic fund transfers (mostly deposits).

1.11 *Retiree Coverage of Spouse/Domestic Partner:* What are the criteria for adding a spouse/domestic partner to a retiree's plan?

New spouses/domestic partners may be added within 60 days of establishing their status. After this period a spouse/domestic partner, or other dependent, may be added during any open enrollment period for coverage to begin with the next plan year.

1.12 *Out-of-state retiree:* I am a Medicare-eligible retiree living out of state. The CalPERS booklet says that the Select plan is not offered in my state (Nevada), but in the workshop information indicated that the Select and Choice plans are identical for Medicare-eligible retirees because the network v. non-network distinction does not apply to Medicare retirees. As I understand it, I must use a provider who accepts Medicare-- whether that provider is in the Blue Cross Select network is irrelevant. So, do I have to buy Choice, or can I buy Select?

No, you cannot enroll in CalPERS Select if you live out of state. The District has repeatedly inquired about this issue, and CalPERS has confirmed to the District that out-of-state retirees, including Medicare-eligible retirees, cannot choose the Select plan. That Select is not available out-of-state is also confirmed in the CalPERS Health Summary, p. 7. If a retiree tries to choose Select during the Open Enrollment, the enrollment will be rejected, and the retiree will be contacted for alternative election. Hence, out-of state residents who wish to enroll in a PPO plan are limited to either PERS Care or PERS Choice only.

1.13: *For retirees on Medicare who choose the CalPERS Select plan:* Are Palo Medical Foundation (PAMF) and the Camino Medical Group covered?

Yes. For Medicare-eligible retirees only, the plan coverage for Select and Choice is identical as is indicated in the *CAlPERS Benefits Summary*. Both plans pay all of the Medicare Part A (hospital) deductibles and co-pays and all of the Medicare Part B (outpatient) deductibles and co-pays for Medicare providers, including the few who accept the Medicare approved amount as the payment in full and the more numerous providers who have an agreement with Medicare to add additional charges. This coverage is not found in all supplemental plans but is essentially the same as provided under UHC.

1.14 ***For Medicare-eligible retirees:*** **If the Choice and Select plans provide identical coverage, why does the Select plan have a lower monthly employee/retiree monthly contribution?**

The District calculation of the employee/retiree monthly contribution is based on a composite rate: that is, a combination of the premium rate for active employees and non-Medicare retires (mostly under age 65) and the premium rate for Medicare-eligible retirees. For employees and non-Medicare retirees, the Select plan offers a subset of the Blue Cross Prudent Buyer PPO network, and PAMF and Camino are excluded. Therefore, the premium—and, hence, the monthly contribution is lower than under Choice. But, as explained in the FAQ above, Medicare-eligible retirees are not limited to the smaller Select network, or any one network for that matter: their only obligation is to obtain services from a Medicare provider.

1.15 ***Retired with pre-existing condition:*** **Do I have to provide proof of prior coverage as stated in the District Benefits Guide, p. 33?**

As long as a retiree has had no break in coverage this year, he or she will be covered without having to meet any pre-existing condition waiting period. In such a situation, the retiree does not need to provide any documentation.

1.16 ***Retiree, checking to see if a doctor is in the network:*** **In the mailed notice from the District, you mention that, when in communication with our doctor, we identify our plan to see if the doctor is covered. You suggest that for Select and Choice, we ask if the doctor is in the Blue Cross Prudent PPO Network. Shouldn't we be asking if he or she is an Anthem Blue Cross participant?**

Blue Cross has a large network (for Choice) and a smaller subset of that network (for Select). So, a particular doctor could be in the Prudent Buyer network and not in the the Select network Correction of the District mailing: For the Select Plan, ask your doctor if he or she is in the Blue Cross Select PPO Network. For the Choice Plan, ask your doctor if he/she is in the Blue Cross Prudent Buyer PPO Network.

That said, as explained above in FAQ 1.14, Medicare-eligible retirees enrolled in the Select plan are not limited to the Select network—or any network for that matter. So, the question to ask any provider is, "Do you accept Medicare?" Also see FAQ 1.13 above.

1.17 ***Benefit beyond Medicare:*** **In the CalPERS Summary, "N/A" appears after "Benefit Beyond Medicare." What does this mean?**

N/A means "Not Applicable": that is, no additional benefit beyond the Medicare-allowed limits. For example, Medicare allows up to 45 visits for Home Health Services per calendar year. The Select and Choice plans also have this limit: 45 visits. Under the more costly Care plan, however, you can get up to 100 visits for Home Health Services per calendar year—this is known as a "benefit beyond Medicare." Care is the only CalPERS PPO Medicare supplemental plan that offers a number of benefits beyond Medicare—but you will notice that it is priced accordingly.

SECTION 2: ACTIVE EMPLOYEES

2.1 *Cross Coverage and Coordination with Other Employer Plans:* If an employee elects a Blue Cross plan and that employee's spouse/domestic partner works for another company and s/he has a Blue Cross plan provided by his or her own employer, what are the limits or rules regarding cross coverage and coordination?

There are no rules imposed by the District regarding this situation; however, coordination of benefits typically apply to these plans. Individuals should read the plan documents for the selected plan to determine what provisions apply.

SECTION 3: SPOUSE/DOMESTIC PARTNERS AND DEPENDENTS

3.1 *April 2012 Open Enrollment:* What verification is required to enroll a spouse/domestic partner/dependent for coverage in the Open Enrollment for July – December 2012?

RETIREES: Jul – Dec 2012 Plan Year Open Enrollment

- Enrollment Form
- Medicare ID Card or Medicare Proof of Coverage (if applicable)
- For Spouse: Marriage Certificate or Notarized Affidavit of Marriage
- For Domestic Partner: Certificate of Marriage or Registered Partnership, or FHDA Affidavit of Domestic Partnership
- For Dependents: Birth Certificate or Notarized Affidavit of Dependent
- For Disabled Dependent Over Age 26:
    - Birth Certificate or Notarized Affidavit of Dependent (if not previously provided)
    - Medical Certification - Parent Form
    - Medical Certification – Medical Provider.

ACTIVE EMPLOYEES: Jul – Dec 2012 Plan Year Open Enrollment

- Enrollment Form
- *If not currently on file with FHDA Benefits:*
    - For Disabled Dependent Over Age 26:
        - Birth Certificate or Notarized Affidavit of Dependent (if not previously provided)
        - Medical Certification - Parent Form
        - Medical Certification – Medical Provider
    - Medicare Eligibility:
        - Medicare ID Card or Medicare Proof of Coverage (if applicable)
    - Spouse/Domestic Partner and Dependent Coverage:
        - For Spouse: Marriage Certificate or Notarized Affidavit of Marriage
        - For Domestic Partner: Certificate of Marriage or Registered Partnership, or FHDA Affidavit of Domestic Partnership

- For Dependents: Birth Certificate or Notarized Affidavit of Dependent.

3.2 *Disabled Dependent Eligibility Past Age 26:* What are the rules of eligibility regarding an active employee's adult (over 26 years of age) *disabled* dependent?

The disabled adult child must have been evaluated and diagnosed as disabled prior to his/her 26th birthday.

3.3 *District Married Couples/Domestic Partners Separate Enrollment:*

a. If a married couple/domestic partners both work(ed) for the District, can they each enroll in their own plan separately? For example, one in Kaiser the other in a CalPERS PPO?

Each employee/retiree may choose his or her own health plan irrespective of the choice a spouse/domestic partner, who is also an employee/retiree, may make; however, an employee/retiree may not be both a subscriber on his/her own plan and a dependent on his/her spouse's/domestic partner's plan (no dual coverage).

b. *District Married Couples/Domestic Partners on Same Plan-One a Dependent of the Other:* If they are enrolled in the same plan, does one have to be enrolled as the dependent of the other?

No, under the CalPERS plans, the two do not have to be adjoined. Adjoining members in this manner does not provide any cost benefit to the District Benefits Budget under CalPERS. However, adjoining/enrolling as one unit is advantageous to the family. In such a case, the cost to enroll the family as one unit is less than if one member joins as employee/retiree only, and the other member joins as employee/retiree plus family.

c. *District Married Couples/Domestic Partners – Covering Children:* If two plans are possible, can they put one child on one plan and one on another?

According to CalPERS rules dependents may not be separated for split coverage; that is, the children can be covered by one plan *or* the other but may not be split with one or more children covered by one plan and remaining one or more children covered by a separate plan.

3.4 *Dependent Child in Different Geographic Region:* If a dependent child lives in a different geographical area, can the parent choose a Plan and still have the dependent child covered by the Plan in different geographic area?

If the Chosen Plan *Has* Providers Available in Both Areas:

- The entire family will need to enroll under one location (e.g. South Bay). Depending on the plan selected, the employee may then need to contact the Chosen Plan (by phone or website) to notify the carrier that the dependent will need to have regular services provided at a different geographic location.

If the Chosen Plan *Does Not Have* Providers Available in Both Areas:

- The employee/retiree will need to enroll in a plan that has providers available in both locations. Alternatively, the dependent child could return to the geographic home to receive covered services from an eligible provider.

SECTION 4: EMPLOYEES LAID-OFF FROM EMPLOYMENT

4.1 *Laid off employee options:* For employees being laid-off at the end of June, who is the provider, and what are the rates?

The provider is CalPERS starting July 1, 2012. The District will pay its usual portion for the first 3 months (with the former employee making the usual employee contributions) and then the former employee must pay the COBRA rates, which are 102% of the premium rates, to continue coverage.

SECTION 5: RESOURCES AND SUPPORT

5.1 *Benefits Workshops*: When are the workshops scheduled?

RETIREE Information Session #1:

Full Presentation: Friday, April 20, 2012 from 11:00 a.m. – 2:00 p.m.

Conference Room A and B in the De Anza - Student Center

Available Presenters/Plan Representatives:

CalPERS, Blue Shield, Kaiser ***and Medicare*** *(On This Date Only)*

RETIREE Information Session #2:

Full Presentation: Tuesday, May 1, 2012 from 1:30 p.m. – 3:00 p.m.

Fireside Lounge in the De Anza - Student Center

This is a repeat session; it will cover the same material as the April 20 session.

RETIREE Onsite Enrollment Help Sessions:

Tuesday, May 1, 2012	Wednesday, May 2, 2012
2:00 p.m. – 4:00 p.m.	2:00 p.m. – 4:00 p.m.
Conference Room A/B	Conference Room A/B
De Anza - Student Center	De Anza - Student Center

Available Presenters/Plan Representatives: CalPERS, Blue Shield, Kaiser

ACTIVE/OPEN Information Session:

Monday, April 30, 2012

1:45 p.m. – 4:30 p.m.

Room 5015

Foothill Forum Building

Available Presenters/Plan Representatives: CalPERS, Blue Shield, Kaiser

Tuesday, May 1, 2012	Wednesday, May 2, 2012

11:00 a.m. - 2:00 p.m. 11:00 a.m. - 2:00 p.m.

Conference Room A/B Conference Room A/B

De Anza - Student Center De Anza - Student Center

Available Presenters/Plan Representatives: CalPERS, Blue Shield, Kaiser

SECTION 6: PLAN PROVISIONS

6.1 *Medical Necessity Partial Waiver:* On page 18/19 of the Summary booklet it uses the term "Medical Necessity/Partial Waiver" - what does this mean?

There may be a reduction in the copay required by the employee/retiree when it is deemed a medical necessity by a provider or pharmacist.

6.2 *Outpatient Coverage Exclusion Re: Skilled Nursing Care:* On page 20/21 of the Summary booklet it states Outpatient coverage not covered; what does this mean? It seems Skilled Nursing Care is not covered; can a nurse come to your home?

The term "Skilled Nursing Care" is an inpatient benefit provided at a hospital or skilled nursing facility but may not be provided by those specific providers on an outpatient basis. Contrary to Skilled Nursing Care, a benefit may be provided by a home health services provider for services at home by a "skilled" professional such as a nurse or home health aide. These are similar to benefits currently provided by the District plan.

6.3 *Long-term Care Plan and PERS Health Plan:* Some people have a long-term care plan through PERS. Can this be billed/combined with the medical plans? How is long-term care affected by the changes to our benefits?

CalPERS long term care is not affected by our benefit changes. The long-term care billing is quarterly and will remain unchanged.

6.4 *Pharmacy Services for PPO and HMO Plans:* Do those planning to stay with or considering enlisting in a Kaiser/Blue Shield HMO plan continue to use the HMO provider pharmacy, as is currently provided with our Kaiser plan?

Yes, persons enrolled in Kaiser or one of the Blue Shield HMO providers must use the HMO pharmacy at their provider location.

For individuals enrolled in a PPO plan, who is the contracted provider and does that provider a) offer online ordering and deliveries by mail; b) allow online tracking of all prescriptions, deliveries, auto billing; and c) allow 90-day prescriptions by mail order without tripling the copay?

For the CalPERS Select, Choice or Care plans, CVS is the contracted provider for pharmacy services.

- CVS offers online ordering and deliveries by mail;
- CVS provides online tracking of prescriptions, deliveries and auto billing; and
- CVS allows 90-day prescriptions by mail order without tripling the copay.

6.5 *Finding Network Providers and other Benefits Information:* How do I find in-network providers; check if my favorite Doctor is in-network; and find out the details of each plan?

These links will be included on the District's Human Resources website on the Benefits page. These websites have contact, coverage and participating physician information.

CalPERS General Information
(select Active Member>School Employee and then Health Benefits Programs)
CalPERS Health Benefits Program (follow the links)
http://www.calpers.ca.gov/index.jsp?bc=/eip/self-id-member.jsp

PPOs
PERS Select/PERS Choice & PERS Care
http://www.anthem.com/ca/calpers/

HMOs
Access+ HMO and NetValue HMO
https://www.blueshieldca.com/bsc/calpers/member/index.jhtml
https://www.blueshieldca.com/bsc/calpers/member/start/index.jhtml

Kaiser HMO

https://prospectivemembers.kaiserpermanente.org/kpweb/healthplans/individualplans.do

MEDICARE & CalPERS FAQs
http://www.calpers.ca.gov/index.jsp?bc=/member/health/medicare/faqs.xml

6.6 Where can I find information regarding the District's Employee Assistance Program (EAP)?

The link is in the left-hand column of the Benefits page on the Human Resources website. EAP information can be found at http://hr.fhda.edu/benefits/EAP.

6.7 *Preventative Care Services:* What preventative services are covered by CalPERS?

Preventive services are provided in accordance with the Health Care Reform Act. As this list continues to be updated members should check with their plan to understand what is covered as there is no single information site that provides information as to all changes.

Health Care Reform mandated the coverage of preventive services rated as "A" or "B" by the Preventive Services Task Force – see http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm .

- Category "A" and "B" preventive services as listed by the U.S. Preventive Services Task Force
- Immunizations recommended by the Centers for Disease Control and Prevention

In addition to the list included at the website link above, additional preventive services have been added and are *currently covered* include the following partial list:

- Screening and counseling for child obesity
- Expanded recommendations for HPV vaccine (including males)
- Expanded recommendations for flu shot for adults ages 19-49
- Expanded recommendations for pneumococcal vaccine for adults ages 19-49
- Expanded recommendations for MMRV vaccine.

Preventive services covered *effective January 2013* will also include the following:

- well-woman visits;
- screening for gestational diabetes;
- human papillomavirus (HPV) DNA testing for women 30 years and older;
- sexually-transmitted infection counseling;
- human immunodeficiency virus (HIV) screening and counseling;
- FDA-approved contraception methods and contraceptive counseling;
- breastfeeding support, supplies, and counseling; and
- Domestic violence screening and counseling.

6.8 *Kaiser Subsidy:* What is the basis for the Kaiser subsidy?

The JLMBC recommended a Kaiser subsidy to ease the transition of those who have been in Kaiser (usually for many years) into the higher-cost CalPERS Kaiser. Prior to now, Kaiser has always been the "cheapest" plan, and the JLMBC determined that the short-term subsidy would be an appropriate gesture in return for past use of the most cost-effective health plan.

6.9 *CalPERS 2013 Rates:* How are we able to distribute a rate sheet when CalPERS will not set the 2013 rate until after we have ratified this change and had the first open enrollment?

Lockton, the District's benefits consultants, used last year's average increase in CalPERS rates to project the 2013 rates. Since the JLMBC wanted to develop an eighteen-month benefit package effective July 1, 2012, it had to set rates before CalPERS announced its 2013 rates in July, 2012.

6.10 *District Contribution of $976:* How did the District arrive at the $976 PEPM figure? Is it likely to change?

The $976 PEPM is a funding mechanism. The number was derived this way in 2009: the District was attempting to eliminate a continuing internal operating deficit. Assuming that the deficit was, in large part, caused by the increasing cost of health benefits, it referred back to the last year in which the District ran a balanced budget—2005-2006. The District took the benefit budget at that time (approximately $24.5M) and divided that by the number of employees and retirees (approximately 2,100) and divided that by 12 months to get the $976PEPM (per employee per month) rate that "the District could afford." This is not a cap; it is subject to negotiation in the future.

6.11 *Plan Changes During the Plan Period:* Can an employee/retiree change his or her plan choice during the plan period?

During the plan period, the employee/retiree's plan choice remains in effect until a new election is made during open enrollment for the next plan period. There are some exceptions, which are deemed life-qualifying events, such as marriage/divorce or birth of a child, that allow for change during the plan period. In addition, an employee whose status changes to "retiree" during the plan period may change his/her plan choice at the time of retirement.

6.12 *Out-of-State Coverage:* What plan should I choose?

Employees and retirees should carefully review the plans and provider availability in the area in which services are to be provided. For example, PERS Select plan is only available to California residents, but PERS Choice

and PERS Care offer coverage out of state. Likewise, Kaiser availability is limited to geographic areas where Kaiser has a facility, and BlueShield HMOs only have providers in certain California geographic area.

6.13 *Pre-existing Conditions:* Do I have to provide proof of prior coverage as stated in the District Benefit Guide?

As long as an employee/ retiree has had no break in coverage this year, he or she will be covered without having to meet any pre-existing condition waiting period. In such a situation, the employee/retiree does not need to provide any documentation.

SECTION 7: FLEXIBLE SPENDING ACCOUNTS

7.1 *Flexible Spending Accounts:* What is the minimum and maximum for these accounts for the 6 month period July 1 - December 31, 2012? For the calendar year 2013?

FSA Plan for July – December 2012:

- Health Care Account:
  - Minimum is split by 50% of $500; 6-month minimum = $250.
  - Maximum is split by 50% of $3000; 6-month maximum = $1500.
- Dependent Care Account:
  - Minimum is split by 50% of $500; 6-month minimum = $250.
  - Maximum is split by 50% of $5000; 6-month maximum = $2500.

FSA Plan for Calendar Year 2013

- Health Care Account:
  - Minimum = $500.
  - Maximum = $2500.
- Dependent Care Account:
  - Minimum = $500.
  - Maximum = $5000.

SECTION 8: PART-TIME FACULTY HEALTH BENEFITS

8.1 *SDI (State Disability Insurance): (Only part-time faculty have SDI. The District covers disability for full time employees; they do not participate in the SDI program.)* Does SDI have anything to do with health benefits for part-time faculty?

SDI is a wage replacement program for part-time faculty and is not tied to the health benefits plans. SDI coverage and procedures will remain unchanged due to a change in health benefit providers.

8.2 *Employee's monthly contribution for six-month period of July 1 – December 31:* Will my monthly contribution be deducted from my payroll check as it has been in the past?

No, not during the six-month period; you will pay by check. Because the Banner system will require a "close-out" of the original plan year (October –

September) deductions, the process for payments covering July 1 – December 31, 2012 will work this way:

1) In May, the "old" deduction will be made from your May payroll;
2) In June, you be *reimbursed* for the May deduction and a part of the April deduction;
3) In July, you will make your July monthly contribution by check to the District for three months of coverage (July, August and September)—so hang on to that June reimbursement!
4) In each month of October, November, and December, you will make your monthly contribution to the District by check.
5) In your December paycheck, you will see that you have been credited with pre-tax status for the contributions made from July through December, 2012. This way, you will experience no tax consequence from paying monthly contributions by check as opposed to through payroll deduction. The 2013 Plan Year will return to the standard practice of payroll deduction.