

NEW EMPLOYEE ORIENTATION MATERIALS CHECKLIST (FACULTY)

Before orientation, please **READ** and **REVIEW** the following information:

- Foothill College Campus Map & Legend (The District HR Office is located in D120) [p. 3]
- Employee/Retiree Monthly Contribution Rates [p. 5]
- Summary of Medical Benefits Table (HMO) [p. 7-8]
- Summary of Medical Benefits Table (PPO) [p. 9-11]
- 2013 CalPERS Health Benefits Summary [p. 13-48]
- Notice of Right to Continue Coverage Under COBRA [p. 49-54]

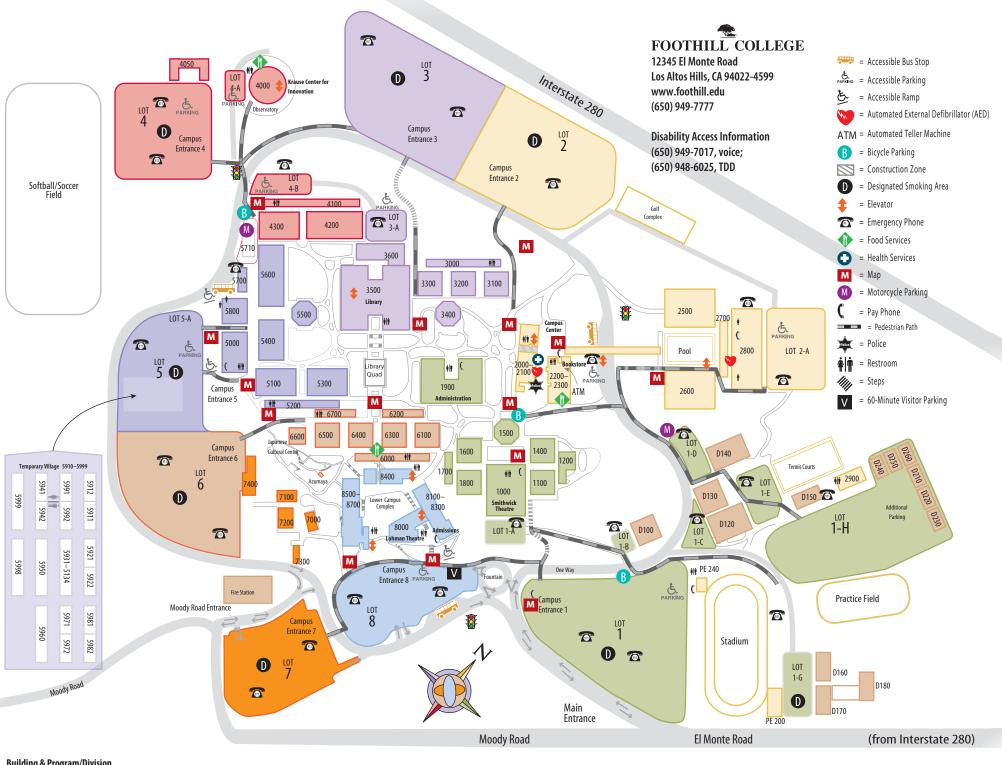
<u>Note</u>: Up-to-date information regarding benefits plans and rates can be reviewed online on our website: http://hr.fhda.edu/benefits.

Before orientation, please PRINT, COMPLETE and SIGN the following documents:

Т	1
 Universal Enrollment Form Choose one of the six (6) plan choices for your entire family For EACH person you insure please include: Marriage Certificate or a California State Declaration of Domestic Partnership (Form NP/SF DP-1) or a California State Confidential Declaration of Domestic Partnership (Form NP/SF DP-1A) (if applicable) OR CalPERS Affidavit of Marriage/Domestic Partnership** (Form PERS-HBSD-1965) (**information will be verified by CalPERS. Claims must be reimbursed if false or inaccurate information is provided.) Copies of Birth Certificates for all eligible dependents (including spouse or domestic partner) Copies of Social Security cards for all eligible dependents (including spouse or domestic partner) Legal adoption notice and/or court orders (if applicable) 	[p. 55-58]
CalPERS Declaration of Health Coverage form (form HBD-12A)	[p. 59-60]
CalPERS Health Benefit Plan Enrollment form (form PERS-HBD-12)	[p. 61-62]
CalPERS Affidavit of Parent-Child Relationship form (optional; if applicable) (form HBD-40)	[p. 63-64]
Member Questionnaire for the CalPERS Disabled Dependent Benefit (form HBD-98) (optional; if applicable)	[p. 65-66]
Medical Report for the CalPERS Disabled Dependent Benefit (form HBD-34) (optional; if applicable)	[p. 67-70]
Flexible Benefits Spending Accounts: Dependent Care and/or Health Care (optional)	[p. 71-72]
Tax Shelter Annuities—403(b) and 457 Information and form (optional)	[p. 77-78]
General Employee Information form	[p. 77-78]
Hartford Life Insurance Beneficiary Designation form	[p. 79]

	U.S. Department of Justice I-9 form [see other file]	See attachment
	W-4 (Federal) and DE-4 (State) Employees' Withholding Allowance Certificate	[p. 81,83]
	Drug-Free Workplace Policy Statement (read and sign)	[p. 87-88]
	Illness & Injury Prevention Memo (General Safety Guidelines) (read and sign p. 94)	[p. 89-94]
	Retirement Election form (read and sign)	[p. 95]
	CalSTRS Beneficiary Designation Instructions and form (read and sign)	[p. 97-102]
	One-Time Option to Elect to Remain in CalPERS form (read and sign) (form ES372) (optional; if applicable)	[p. 97-102]
	Statement Concerning Your Employment in a Job Not Covered by Social Security (read and sign)	[p. 107- 108]
	Faculty Association (FA) Membership Enrollment form	
	<u>Please note:</u> the "FACCC Membership Benefits" are <u>optional</u> . This is the state level of the Faculty Association and is not locally operated through the District. Checking the "Accept" box will sign you up for state membership dues deduction, <u>in addition to</u> your required FHDA FA membership dues.	[p. 109-110]
	Child Abuse Reporting form (read and sign)	[p. 111-112]
Please	BRING the following to orientation:	
	Employee's Social Security card <u>and</u> government-issued picture ID (see the I-9 form for acceptable documents)	
	Note: You will need to provide the <i>actual</i> documents, not photocopies; Social Security card exempted	-
	Any documentation for dependents you are enrolling into the health plan (see documents listed under Universal Enrollment Form above)	-
	All of the above (applicable) documents—printed, signed and dated	_
During	After orientation, please COMPLETE the following forms and task	<s:< td=""></s:<>
	TB (Tuberculosis) Testing/Livescan Services Schedule & Contact Information	[p. 113]
	TB (Tuberculosis) Test form (Visit Health Services on the Foothill or De Anza campuses for the test. After results are read, the form will be automatically returned to HR by Health Services. Service is <i>free</i> for employees.)	[p. 114]
	Request for Live Scan Service form (Complete the middle section only. ** Required process; you will receive this form during orientation. Service is <u>free</u> for employees.)	**
	Direct Deposit (follow-up with Personnel (650-949-6219) within 7-10 days to confirm your employee CWID so that you may access https://myportal.fhda.edu and sign up for direct deposit. You may only do this online . Until you sign up, you will continue to receive paper paychecks in the mail.)	
FYI	Change of Address (Can only be done online via MyPortal: https://myportal.fhda.edu Address must be changed within 10 calendar days of new effective date.)	
FYI	Change of Name (Can only be done by notifying Personnel in writing. Must provide a copy of new official social security card. Only the names presented on your social security card will be acknowledged as official. Must notify Personnel within 10 calendar days of name change effective date.)	





Building & Program/Division

D100-180 Chancellor's Office (D120) & District Central Services 2200 **Food Services** 1000 Smithwick Theatre 2300 Bookstore, Hearthside Lounge 1100-1800 Fine Arts & Communication 2500-2800 Physical Education & Athletics 1500 Appreciation Hall 3000-3400 **Business & Social Sciences** 1900 President's Office 3500-3600 Library, Media Center & Tutorial Center 2000 Student Activities Office & ASFC Smart Shop 4000 Krause Center for Innovation & Print Shop 2100 Intramurals, Middle College, Health Services & Police 4100–4300 Computers, Technology & Information Systems 5100-5300 **Biological & Health Sciences** 5312 **Dental Clinic** 5400-5700 Physical Sciences, Mathematics & Engineering 5800 Adaptive Learning & Disability Services 5900 Temporary Village 6000-6500 Language Arts Japanese Cultural Center

6700 **Biological & Health Sciences** 7000-7300 Environmental Horticulture & Design & Veterinary Technology 8000 Lohman Theatre 8100 Admissions 8200 EOPS, Financial Aid, Testing 8300 Counseling, Transfer Center 8500-8700 **Biological & Health Sciences**

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

Foothill-De Anza Community College District	CalPERS HMO Plans 2013 Benefits (ACTIVES/RETIREES/SURVIVORS)					
SUMMARY PLAN COMPARISONS						
	Blue Shield Access+					
Blood Book (1919)	Water	(includes PAMF &	Blue Shield NetValu			
Plan Provisions	Kaiser	SCCIPA)	(excludes PAMF)			
Plan	In Network	In Network	In Network			
Plan Type	НМО	НМО	НМО			
Deductible (Calendar Year)	\$0/person \$0/family	\$0/person \$0/family	\$0/person \$0/family			
Dut of Pocket Maximum	\$1,500/person	\$1,500/person	\$1,500/person			
ifetime Maximum Limit	\$3,000/family No Limit	\$3,000/family No Limit	\$3,000/family No Limit			
Office Visits - Primary Care	\$15 copay	\$15 copay	\$15 copay			
Office Visits - Specialists	\$15 copay	\$30 copay	\$30 copay			
		No, if in same physician me	ed group such as PAMF or			
Specialist Referral Required?	YES	SCCI				
Coinsurance You Pay	0%	0%	0%			
Hospital Copay Dutpatient Services	No Charge \$15 Per Procedure	No Cha \$0 - (\$250 copay for s				
Surgery/Anesthesia	\$15 Outpatient	No Cha				
Preventative Care	\$0	\$0	\$0			
Allergy Testing/Treatment Diagnostic X-ray and Lab	\$15 testing Some Copays	No Cha No Cha	<u>u</u>			
OXL with Physician OV	\$0	\$0	\$0			
Chiropractic Care	Not Covered Not Covered	Not Co				
Chiropractic Annual Maximum	\$15 copay when med	Not Cov	vei eu			
Acupuncture Care	necessary	Not Cov				
Acupuncture Maximum	None	Not Cov	vered			
Jrgent Care	\$15 copay	\$15 copay/visit - Authorization care that involves a surgical or ot				
	\$50 Copay (waived if		\$50 Copay (waived if			
Emergency Room Emergency Room Services	admitted) 100%	\$50 Copay (waived if admitted) 100%	admitted) 100%			
f Emergency Criteria Not Met	Not Applicable	Not Applicable	Not Applicable			
Mental Health		·				
Inpatient	No Charge	No Cha	arge			
Outpatient Substance Abuse	\$15 copay for individual, \$7 copay for group	\$15 copay	\$15 copay			
Inpatient	No Charge	No Cha				
Outpatient Ambulance	\$15 copay No Charge	\$15 copay No Cha	\$15 copay			
Home Health Care	No Charge	No Cha				
Home Health Care Visit Limit	No Limit	No Limit	No Limit			
Hospice Hospice Care Lifetime Limit	No Charge No Limit	No Cha No Limit	arge No Limit			
Danier d'avail (Dhaois al (Caras als Thaosan						
Occupational/Physical/Speech Therapy Inpatient	No Charge	No Cha	arne			
Outpatient	\$15 copay	\$15 copay	\$15 copay			
Pre-Certification Required	Not Required	Not Required	Not Required			
Skilled Nursing Care	No Charge - Up to 100					
Inpatient	days	No Charge - Up to 100 c				
Outpatient	Not Covered	Not Cov	vered			
/ision Exam	No Charge	No Charge (limited to one visit paged 18 and over. No limit on under age 18). Eye glasses are eyeglasses that are necessare.	number of visits for Member are not covered, except for			
learing Exam	No Charge	No Cha	arge			
Hearing Aids Hearing Aid Frequency	\$1,000 Every 36 months	First \$1,000 Every 36 months) covered Every 36 months			
Ourable Medical Equipment	No Charge	No Cha				
OME Precertification	Not Required	Not Required No Limit	Not Required			
rosthetic Device Limit	No Limit	NO LIMIL	No Limit			
nfertility Services	50% of Allowed Charges	50% of Allow	ed Charges			
Prescription Drugs						
Retail	\$5 Copay/30 days , \$10					
Generic	for 31-60 days, or \$15 for a 61-100-day supply	\$5 Copay/30 days	\$5 Copay/30 days			
555110	, <u></u>		φο συραγίου days			
Brand Formulary	\$20 Copay/30 days , \$40 for 31-60 days, or \$60 for a 61-100-day supply	\$20 Copay/30 days	\$20 Copay/30 days			
Brand Non-Formulary	N/A	\$50 Copay/30 days - \$3				
Retail Maintenance after 3 months of		Generic substitution pena				
ill		differe	nce)			

2013 Benefits Summary Plan Comparison - PERS HMOs (ACTIVES/RETIREES/SURVIVORS)

Foothill-De Anza Community College District	CalPERS HMO Plans					
SUMMARY PLAN COMPARISONS	2013 Benefits (ACTIVES/RETIREES/SURVIVORS)					
Plan Provisions	Kaiser	Blue Shield Access+ (includes PAMF & SCCIPA)	Blue Shield NetValue (excludes PAMF)			
Plan	In Network	In Network	In Network			
Plan Type	НМО	НМО	НМО			
Brand Formulary	\$20 Copay/30 days	\$40 Copay/30 days	\$40 Copay/30 days			
Brand Non-Formulary	N/A	\$100 Copay/30 days	\$100 Copay/30 days			
Mail Order						
Generic	\$5 Copay/30 days, \$10 for 31-100-day supply	\$10 Copay/90 days	\$10 Copay/90 days			
Brand Brand Non-Formulary	\$20 Copay/30 days, \$40 for 31-100-day supply N/A	\$40 Copay/90 days \$100 Copay/90 days	\$40 Copay/90 days \$100 Copay/90 days			
Rx Copay Maximum/person	No max	\$1,000 per person	\$1,000 per person			
Out-of-Plan Coverage	Emergency Only	Blue Card	Blue Card			

NOTE: Discretionary drugs are subject to 50% co-insurance. These are products used to treat non-life threatening conditions such as erectile or sexual dysfunction, and restricted for short-term or acute illness.

All HMO products offered free of charge for contraceptive drugs and devices.

Blue Shield HMOs: \$1,000 Out-of-Pocket Maximum, per person each calendar year excluding non-Preferred Brand-Name Medication copayments, Distretionary Drug coinsurance for erectile or sexual dysfunction, and "Member Pays the Difference" differential.

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

2013 Benefits Summary Plan Comparisons - PERS PPOs (ACTIVES)

			CalPEI	RS PPO Plans			
	our Exo I To I falls						
Foothill-De Anza Community College District	2013 Benefits - ACTIVES ONLY						
					PERS Select (Excludes Sutter		
Plan Provisions	PERS	Care	PERS CH	noice	Health/	PAMF)	
SUMMARY PLAN COMPARISONS	Includes access to	Sutter Health/PAN	//F; Available for Out-0	f-State residents	Services is not available Counties; Restricted t		
	Preferred Prov	s' PRUDENT BUYER riders Network	Anthem Blue Cross' Preferred Provid	lers Network	Anthem Blue Cross' SE Providers	Network	
Plan	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	
Plan Type	Open Ac	cess PPO	Open Acce	ss PPO	Select Netv	vork PPO	
Deductible (Calendar Year)	\$500/	person	\$500/ pe	rson	\$500/ p	erson	
	\$1,000	/family	\$1,000/fa	amily	\$1,000/	family	
Deductible Apply to OOP max?	No	No maximum	No	No maximum	No	No maximum	
Out-of-Pocket Annual Maximum (Only	\$2,000/person	No maximum	\$3,000/person	No maximum	\$3,000/person	No maximum	
Coinsurance applies)	\$4,000/family	No maximum	\$6,000/family	No maximum	\$6,000/family	No maximum	
Lifetime Maximum	No maximum	No maximum	No maximum	No maximum	No maximum	No maximum	
Office Visits - Primary Care	\$20 copay	40% after Deductible	\$20 copay	40% after Deductible	\$20 copay	40% after Deductible	
Office Visits - Specialists	\$20 copay	40% after Deductible	\$20 copay	40% after Deductible	\$20 copay	40% after Deductible	
Coinsurance You Pay	10%	40%	20%	40%	20%	40%	
Hospital Copay	\$250 Deductible per confinement		\$0 copay per confinement		\$0 copay per confinement		
Hospital Coinsurance	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible	
Outpatient Services	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible	
Surgery/Anesthesia	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible	
Preventative Care	\$0	40% after Deductible	\$0	40% after Deductible	\$0	40% after Deductible	
Allergy Testing/Treatment	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	
-	10% after Deductible		20% after Deductible				
Diagnostic X-ray and Lab		40% after Deductible		40% after Deductible	20% after Deductible	40% after Deductible	
DXL with Physician OV	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	
Chiropractic Care	10% after Deductible 20 Combined Chiro/A	40% after Deductible cupuncture Visits Per	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	
Chiropractic Maximum Annual Visits Limit Acupuncture Care	Ye 10% after Deductible	40% after Deductible	15 Combined Chiro/Acupu 20% after Deductible	ncture Visits Per Year	15 Combined Chiro/Acup 20% after Deductible	uncture Visits Per Year 40% after Deductible	
Acupuncture Maximum Annual Visits Limit		puncture Visits Per Year	15 Combined Chiro/Acupu		15 Combined Chiro/Acup		
Urgent Care	\$20 Copay	40% after Deductible	\$20 Copay	Deductible	\$20 Copay	40% after Deductible	
Emergency Room Emergency Room Services	\$50 ER Deductible (waived if admitted)	\$50 ER Deductible (w	aived if admitted)	\$50 ER Deductible (v		
Emergency Room Services	10% after Deductible -	40% after Deductible -		40% after Deductible -			
If Emergency Criteria Not Met	ER facility charge not covered	ER facility charge not covered	20% after Deductible - ER facility charge not covered	ER facility charge not covered	20% after Deductible - ER facility charge not covered	40% after Deductible - ER facility charge not covered	
Mental Health	\$250 Deductible, then			40% after			
Inpatient Outpatient	10% 10% after Deductible	40% after Deductible	20% after Deductible	Deductible 40% after Deductible	20%-30% after Deductible	40% after Deductible	
Outpatient Substance Abuse		40% after Deductible	20% after Deductible	40% arrer Deductible	20%-30% after Deductible	40% after Deductible	
Inpatient	\$250 Deductible, then 10%	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible	
Outpatient	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible	
Ambulance Home Health Care	20% after 10% after Deductible	Deductible 40% after Deductible	20% after De 20% after Deductible	ductible 40% after Deductible	20% after Deductible	eductible 40% after Deductible	
Home Health Care Visit Limit	100 visit per	calendar year	45 visits per ca	lendar year	45 visits per ca	alendar year	
Hospice	10% after	Deductible	20% after De	eductible	20% after D	eductible	

2013 Benefits Summary Plan Comparisons - PERS PPOs (ACTIVES)

			CalPEI	RS PPO Plans		
Foothill-De Anza Community College District	2013 Benefits - ACTIVES ONLY					
Plan Provisions	PERS	PERSCare PERS Choice		PERS Select (Excludes Sutter Health/PAMF)		
SUMMARY PLAN COMPARISONS			ЛF; Available for Out-0	f-State residents	Services is not available Counties; Restricted t	
Plan		PRUDENT BUYER riders Network Out of Network	Anthem Blue Cross' I Preferred Provid		Anthem Blue Cross' SE Providers In Network	
Plan Type Hospice Care Lifetime Limit Occupational/Physical/Speech Therapy	Open Acc No I		Open Acces No lim		Select Netv	
Inpatient Outpatient	No Cl 20% after		No Char 20% after Deductible	ge 40% after Deductible	No Cha 20% after Deductible	arge 40% after Deductible
Pre-Certification Required	No precer		> 24 Vi		> 24 V	
Skilled Nursing Care Inpatient	10% 1st 10 days, 20% next 170 days, precert req, 180 days max per year	40%, precert req, 180 days max per year	20% 1st 10 days, 30% next 90 days, precert req, 100 days max per year	40%, precert req, 100 days max per year	20% 1st 10 days, 30% next 90 days, precert req, 100 days max per year	40%, precert req, 100 days max per year
Outpatient	Not co	overed	Not cove	red	Not cov	ered
Vision Exam	Not covered		Not covered		Not covered	
Hearing Exam Hearing Aids	10% after Deductible 10% after Deductible	40% after Deductible 40% after Deductible	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Hearing Aid Frequency	one device every 36 months		one device every 36 months		one device every 36 months	
Durable Medical Equipment	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
DME Precertification	> \$1	,000	> \$1,0	00	> \$1,	000
Prosthetic Device Limit	No I	imit	No limit		No limit	
Infertility Services Prescription Drug	Not co	overed	Not cove	red	Not cov	rered
Retail Pharmacy Network						
Generic	\$5 Copay	r/30 days	\$5 Copay/3	0 days	\$5 Copay/	30 days
Brand Formulary (Preferred)	\$20 Copa	y/30 days	\$20 Copay/3	80 days	\$20 Copay	/30 days
Brand Non-Formulary (Non-Preferred)****	\$50 Copa	y/30 days	\$50 Copay/30 days		\$50 Copay/30 days	
Partial Waiver of non-preferred brand***	\$40 Copa	y/30 days	\$40 Copay/30 days		\$40 Copay/30 days	
Retail Maintenance Choice®*						
Generic	\$10 Copa	y/90 days	\$10 Copay/9	00 days	\$10 Copay	/90 days
Brand Formulary (Preferred)	\$40 Copa	y/90 days	\$40 Copay/9	00 days	\$40 Copay	/90 days
Brand Non-Formulary (Non-Preferred)****	\$100 Cop	ay90 days	\$100 Copay90 days		\$100 Copay90 days	
Partial Waiver of non-preferred brand***	\$70 Copa	y/90 days	\$70 Copay/	00 days	\$70 Copay	/90 days
CVS Caremark Rx Mail Service						
Generic	\$10 Copay/90 days	Not Available	\$10 Copay/90 days	Not Available	\$10 Copay/90 days	Not Available
Brand Formulary (Preferred)	\$40 Copay/90 days	Not Available	\$40 Copay/90 days	Not Available	\$40 Copay/90 days	Not Available
Brand Non-Formulary (Non-Preferred)****	\$100 Copay/90 days	Not Available	\$100 Copay/90 days	Not Available	\$100 Copay/90 days	Not Available
Partial Waiver of non-preferred brand***	\$70 Copa	y/90 days	\$70 Copay/9	00 days	\$70 Copay	/90 days
Rx Copay Maximum/person**	\$1,000	D/year	\$1,000/	ear	\$1,000	/year

2013 Benefits Summary Plan Comparisons - PERS PPOs (ACTIVES)

	CalPERS PPO Plans					
Foothill-De Anza Community College District			ILY			
Plan Provisions	PERS	SCare SCare	PERS CI	noice	PERS Select (Excludes Sutter Health/PAMF)	
SUMMARY PLAN COMPARISONS	Includes access to	Sutter Health/PAN	/IF; Available for Out-C	f-State residents	Services is not available Counties; Restricted t	
	Anthem Blue Cross' PRUDENT BUYER Preferred Providers Network		Anthem Blue Cross' Preferred Providence		Anthem Blue Cross' SI Providers	
Plan	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Plan Type	Open Access PPO		Open Access PPO		Select Netv	work PPO

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 50% co-insurance. These are products used to treat non-life threatening conditions such as erectile or sexual dysfunction.

To obtain a partial copayment waiver, your physician nust substantiate medical necessity for the non-preferred product vs. the preferred product(s) and the available generic alternative(s) by faxing to CVS at 1-866-689-3092.

*Retail Maintenance Choice® are available only through CVS Drugs Stores, not offered through any other CVS contracted retail pharmacies.

**Rx Out-of-Pocket Maximum, per person each calendar year excluding non-Preferred Brand-Name Medication copayments, Distretionary Drug coinsurance for erectile or sexual dysfunction, and "Member Pays the Difference" differential.

***Your physician must substantiate the medical necessity for the Non-Preferred product vs the Preferred product(s) and the available generic alternative(s) through CVS Caremark's formal appeals process

****Member Pays the Difference. For brand name medications, where a U.S. Food and Drug Administration (FDA) approved generic equivalent is available, the Member will pay the difference in cost between the brand medication and its generic equivalent, plus the applicable generic copayment.

IMPORTANT: Under PERS Select Plan, they have a tiered Narrow Hospital Network, with varying coinsurance. Tier One hospitals, which are those with the best-reimbursement rates, will have an 80 percent coinsurance coverage and \$3000/\$6000 (member/family) maximum out-of-pocket expense. Tier two hospitals will have reduced coinsurance coverage of 70 percent and have an increased maximum out-of-pocket expense of \$6000/\$12000 (member/family). The elective use of non-participating hospitals will remain at 60 percent coverage with NO maximum out-of-pocket application.

document. Your rights and obligations under the program(s) are set forth in the official plan documents. All statements in this summary are subject to the terms of the official plan documents, as interpreted by the appropriate plan fiduciary. In the case of an ambiguity or outright conflict between a provision in this summary and a provision in the plan documents, the terms of the plan documents control. The employer reserves the right to review, change, or terminate the plan, or any benefits under it, for any reason, at any time and without advance notice to any person.

2013 Health Benefit Summary

Helping you make an informed choice about your health plan





CalPERS health plans are administered under the Public Employees' Medical Hospital Care Act, a California State law. Nevertheless, as federal regulations related to the various elements of health care reform are released, CalPERS may need to modify benefits. For up-to-date information about your CalPERS health benefits and health care reform, please refer to the Health Benefits Program link on CalPERS On-Line at www.calpers.ca.gov.

About This Publication

The 2013 Health Benefit Summary provides valuable information to help you make an informed choice about your health plan and health care providers. This publication compares covered services, co-payments, and benefits for each CalPERS health plan. It also provides information about plan availability by county and a chart summarizing the key differences between a Health Maintenance Organization (HMO) and a Preferred Provider Organization (PPO).

You can use this information to determine which health plan offers the services you need at the cost that works for you. The 2013 health plan premiums are available at CalPERS On-Line at www.calpers.ca.gov. Check with your employer to find out how much they contribute toward your premium.

Evidence of Coverage Booklets

The 2013 Health Benefit Summary provides only a general overview of benefits. It does not include details of all covered expenses or exclusions and limitations. Please refer to each health plan's Evidence of Coverage (EOC) booklet for the exact terms and conditions of coverage. Health plans mail EOCs to new members at the beginning of the year, and to existing members upon request. In case of a conflict between this summary and your health

plan's EOC, the EOC establishes the benefits that will be provided. (Note: Some health plans require binding arbitration to resolve disputes. Please refer to the plan's 2013 EOC for more information.)

This publication is to be used only in conjunction with the current year's rate schedule and EOCs. To obtain a copy of the rate schedule for any health plan, please go to CalPERS On-Line at www.calpers.ca.gov or contact CalPERS at 888 CalPERS (or 888–225–7377).

Other Health Publications

This publication is one of many resources CalPERS offers to help you choose and use your health plan. Others include:

- Health Program Guide
 Describes Basic and Medicare health plan eligibility, enrollment, and choices
- CalPERS Medicare Enrollment Guide
 Provides information about how Medicare works
 with your CalPERS health benefits

You can obtain the above publications and other information about your CalPERS health benefits through my|CalPERS at my.calpers.ca.gov or by calling CalPERS at 888 CalPERS (or 888–225–7377).

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CalPERS Health Program Vision Statement

CalPERS will lead in the promotion of health and wellness of our members through best-in-class, data-driven, cost-effective, quality, and sustainable health benefit options for our members and employers.

We will engage our members, employers, and other stakeholders as active partners in this pursuit and be a leader for health care reform both in California and nationally.

Considering Your Health Plan Choices

Selecting a health plan for yourself and your family is one of the most important decisions you will make. This decision involves balancing the cost of each plan, along with other features, such as access to doctors and hospitals, pharmacy services, and special programs for managing specific medical conditions. Choosing the right plan ensures that you receive the health benefits and services that matter to you.

If you are a new CalPERS member or you are considering changing your health plan during Open Enrollment, you will need to make two related decisions:

- Which health plan is best for you and your family?
- · Which doctors and hospitals do you want to provide your care?

The combination of health plan and providers that is right for you depends on a variety of factors, such as whether you prefer a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO); your premium and out-of-pocket costs; and whether you want to have access to specific doctors and hospitals. You may also want to consider how other CalPERS members rate the health plans.

We realize that comparing health plan benefits, features, and costs can be complicated. This section provides information that can simplify your decisionmaking process. As you begin that process, the following are some questions you should ask:

- Do you prefer to receive your health care from an HMO or PPO? Your preference will impact the plans available to you, your access to health care providers, and how much you pay for certain services. See the chart on the next page for a summary of the differences between HMO and PPO plans.
- What are the costs (premiums, co-payments, deductibles, and out-of-pocket costs)? Beginning on page 14 of this booklet, you will find information about benefits, co-payments, and covered services. Visit CalPERS On-Line at www.calpers.ca.gov to find out what the premiums are for the various plans.
- Does the plan provide access to the doctors and hospitals you want? Contact health plans directly for this information. See the "Health Plan Directory" on page 12 of this booklet for health plan contact information.

Understanding How HMO and PPO Plans Work

The following chart will help you understand some important differences between HMO and PPO health plans.

Features	нмо	PP0
Accessing health care providers	Contracts with providers (doctors, medical groups, hospitals, labs, pharmacies, etc.) to provide you services at a fixed price	Gives you access to a network of health care providers (doctors, hospitals, labs, pharmacies, etc.) known as preferred providers
Selecting a primary care physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs ¹	Does not require you to select a PCP
Seeing a specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Allows you access to many types of services without receiving a referral or advance approval
Obtaining care	Generally requires you to obtain care from providers who are a part of the plan network Requires you to pay the total cost of services if you obtain care outside the HMO's provider network without a referral from the health plan (except for emergency and urgent care services)	Encourages you to seek services from preferred providers to ensure your deductibles and co-payments are counted toward your calendar year out-of-pocket maximums ² Allows you the option of seeing non-preferred providers, but requires you to pay a higher percentage of the bill ³
Paying for services	Requires you to make a small co-payment for most services	Limits the amount preferred providers can charge you for services Considers the PPO plan payment plus any deductibles and co-payments you make as payment in full for services rendered by a preferred provider

 $^{^{\,1}}$ Your PCP may be part of a medical group that has contracted with the health plan to perform some functions, including treatment authorization, referrals to specialists, and initial grievance processing.

 $^{^{2}\,}$ Once you meet your annual deductible and co-insurance, the plan pays 100 percent of medical claims for the remainder of the calendar year; however, you will continue to be responsible for co-payments for physician office visits, pharmacy, and other services.

³ Non-preferred providers have not contracted with the health plan; therefore, you will be responsible for paying any applicable member deductibles or co-payments, plus any amount in excess of the allowed amount.

CalPERS HMO and PPO Health Plan Choices

Depending on where you reside or work, your Basic and Medicare health plan options may include the following:

Basic HMO Health Plans	Basic PPO Health Plans	Supplement to Medicare HMO Health Plans	Supplement to Medicare PPO Health Plans	HMO Medicare Managed Care Plans (Medicare Advantage)	Out-of-State Plan Choices
Blue Shield Access+ Blue Shield NetValue Kaiser Permanente California Correctional Peace Officers Association (CCPOA) Medical Plan 2	PERS Select PERS Choice PERSCare California Association of Highway Patrolmen (CAHP) Health Plan ² Peace Officers Research Association of California (PORAC) Police and Fire Health Plan ²	Blue Shield Access+ Blue Shield NetValue CCPOA Medical Plan ²	PERS Select PERS Choice PERSCare CAHP Health Plan ² PORAC Police and Fire Health Plan ²	Kaiser Permanente Senior Advantage Blue Shield 65 Plus ³	PERS Choice (PPO) PERSCare (PPO) Kaiser Permanente (HMO) ^{1, 4} PORAC Police and Fire Health Plan (PPO) ²

Note: CalPERS also offers both Basic and Medicare enrollees in Colusa, Mendocino, and Sierra counties the choice of selecting the Blue Shield Exclusive Provider Organization (EPO) Health Plan. See the current *Health Program Guide* for more information about EPOs as well as detailed health plan eligibility and enrollment guidelines.

- ¹ Kaiser Permanente requires binding arbitration.
- ² You must belong to the specific employee association and pay applicable dues to enroll in an Association Plan (CCPOA, CAHP, or PORAC).
- ³ This is the Medicare Advantage plan for Blue Shield NetValue and Access+.
- ⁴ Kaiser Permanente (HMO) is available in parts of the following states: CO, GA, HI, MD, OH, OR, VA, WA, and Washington, D.C. Costs and some benefits may vary outside of California.

Contacting a Health Plan

If you have a specific question about a plan's coverage, benefits, or participating providers, please contact the plan directly. See the "Health Plan Directory" on page 12 for health plan contact information.

Choosing Your Doctor and Hospital

Once you choose a health plan, you should find a primary care physician. Except in the case of an emergency, the doctors you can use — and the medical groups and hospitals you will have access to - will depend on your choice of health plan.

Many people find their doctor by asking neighbors or co-workers for a doctor's name. Others receive referrals from doctors they already know. Still others simply pick a physician from their health plan who happens to be nearby. Once you choose a doctor, call the doctor's office and ask if he or she affiliates with the plan you are selecting and the hospital you prefer to use. You can also use the Health Plan Chooser tool (described on pages 8-9), which is available on the CalPERS website at www.calpers.ca.gov to find out which plans include your doctor. Either way, you should confirm that the doctor is taking new patients in the plan you select.

If you need to be hospitalized, your health plan or medical group will have certain hospitals that you are able to use. If you prefer a particular hospital, you should make sure the health plan you select contracts with that hospital. See the chart on page 13 for a list of resources that can help you evaluate and select a doctor and hospital.

Enrolling in a Health Plan Using Your Residential or Work ZIP Code

Some of our health plans are available only in certain counties and/or ZIP Codes. As you consider your health plan choices, you should determine which health plans are available in the ZIP Code in which you are enrolling.

In general, if you are an active employee or a working CalPERS retiree, you may enroll in a health plan using either your residential or work ZIP Code. To enroll in a Medicare Advantage plan, you must use your residential address.

If you are a retired CalPERS member, you may select any health plan in your residential ZIP Code area. You cannot use the address of the CalPERScovered employer from which you retired to establish ZIP Code eligibility.

If you use your residential ZIP Code, all enrolled dependents must reside in the health plan's service area. When you use your work ZIP Code, all enrolled dependents must receive all covered services (except emergency and urgent care) within the health plan's service area, even if they do not reside in that area.

To determine if the health plan you are considering provides services where you reside or work, see the "Health Plan Availability by County" chart on the following page. If you have questions about plan availability or coverage, or wish to obtain a copy of the Evidence of Coverage, contact the health plans using the "Health Plan Directory" on page 12.

Health Plan Availability by County

Some health plans are available only in certain counties and/or ZIP Codes. Use the chart below to determine if the health plan you are considering provides services where you reside or work. Contact the plan before enrolling to make sure they cover your ZIP Code and

that their provider network is accepting new patients in your area. You may also use our online service, the Health Plan Search by ZIP Code, available at www.calpers.ca.gov.

County	Blue Shield Access+ & EP0	Blue Shield NetValue	Blue Shield 65 Plus	САНР	ССРОА	Kaiser Permanente	PERS Choice	PERS Select	PERSCare	PORAC
Alameda	•			•	•	•	•	•	•	•
Alpine				•			•	•	•	•
Amador				•		•	•	•	•	•
Butte	•			•	•		•	•	•	•
Calaveras				•			•	•	•	•
Colusa	A			•			•	•	•	•
Contra Costa	•	•	•	•	•	•	•	•	•	•
Del Norte				•			•	•	•	•
El Dorado	•	•		•	•	•	•	•	•	•
Fresno	•	•	•	•	•	•	•	•	•	•
Glenn	•			•	•		•	•	•	•
Humboldt	•	•		•			•	•	•	•
Imperial	•	•	•	•	•		•	•	•	•
Inyo				•			•	•	•	•
Kern	•	•	•	•	•	•	•	•	•	•
Kings	•	•		•	•	•	•	•	•	•
Lake				•			•	•	•	•
Lassen				•			•	•	•	•
Los Angeles	•	•	•	•	•	•	•	•	•	•
Madera	•	•	•	•	•	•	•	•	•	•
Marin	•	•		•	•	•	•	•	•	•
Mariposa	•			•	•	•	•	•	•	•
Mendocino	A			•			•	•	•	•
Merced	•			•	•		•	•	•	•
Modoc				•			•	•	•	•
Mono				•			•	•	•	•
Monterey				•			•	•	•	•
Napa				•		•	•	•	•	•
Nevada	•	•	•	•	•		•	•	•	•
Orange	•	•	•	•	•	•	•	•	•	•

Chart Legend

- Health plan covers all or part of county.
- ▲ The Blue Shield Exclusive Provider Organization (EPO) plan serves Colusa, Mendocino, and Sierra counties only. The EPO plan offers the same covered services as the Access+ HMO plan, but members must seek services from Blue Shield's network of preferred providers. Members are not required to select a primary care physician.

County	Blue Shield Access+ & EPO	Blue Shield NetValue	Blue Shield 65 Plus	САНР	ССРОА	Kaiser Permanente	PERS Choice	PERS Select	PERSCare	PORAC
Placer	•	•		•	•	•	•	•	•	•
Plumas				•			•	•	•	•
Riverside	•	•	•	•	•	•	•	•	•	•
Sacramento	•	•		•	•	•	•	•	•	•
San Benito				•			•	•	•	•
San Bernardino	•	•	•	•	•	•	•	•	•	•
San Diego	•	•		•	•	•	•	•	•	•
San Francisco	•	•	•	•	•	•	•	•	•	•
San Joaquin	•	•	•	•	•	•	•	•	•	•
San Luis Obispo	•	•	•	•	•		•	•	•	•
San Mateo	•	•		•	•	•	•	•	•	•
Santa Barbara	•			•	•		•	•	•	•
Santa Clara	•	•		•	•	•	•	•	•	•
Santa Cruz	•	•		•	•		•	•	•	•
Shasta				•			•	•	•	•
Sierra	A			•			•	•	•	•
Siskiyou				•			•	•	•	•
Solano	•			•	•	•	•	•	•	•
Sonoma	•	•		•	•	•	•	•	•	•
Stanislaus	•	•		•	•	•	•	•	•	•
Sutter				•		•	•	•	•	•
Tehama				•			•	•	•	•
Trinity				•			•	•	•	•
Tulare	•			•	•	•	•	•	•	•
Tuolumne				•			•	•	•	•
Ventura	•	•	•	•	•	•	•	•	•	•
Yolo	•	•		•	•	•	•	•	•	•
Yuba				•		•	•	•	•	•
Out-of-State						•	•		•	•

Tools to Help You Choose Your Health Plan

This section provides a variety of information that can help you evaluate your health plan choices. Included here are details about using my|CalPERS, the Health Plan Chooser, and the Health Plan Choice Worksheet,

as well as information about health plan ratings based on our annual member survey. The section also includes a tip about how you can save money by selecting a high-performance network.

Accessing Health Plan Information with my|CalPERS

You can use my|CalPERS at my.calpers.ca.gov, our secure, personalized website, to get one-stop access to all your current health plan information, including details about which family members are enrolled. You can also use it to search for other health plans that are available in your area, access CalPERS Health Program

forms, and find additional information about CalPERS health plans. If you are a retiree, CalPERS is your Health Benefits Officer. Retirees may change their health plan during Open Enrollment by calling us toll free at 888 CalPERS (or 888-225-7377).

Comparing Your Options: Health Plan Chooser

The Health Plan Chooser is an online tool that provides a convenient way to evaluate your health plan options and make a decision about which plan is best for you and your family. With this easy-to-use tool, you can weigh plan benefits and costs, search for specific doctors, and view overall plan satisfaction ratings.

The Chooser is available to help you make health plan decisions at any time. You can use it to:

- Find a new health plan during Open Enrollment.
- · Select your primary care doctor or find a new specialist.
- · Evaluate your health plan options and estimate costs.
- Choose a health plan when your employer first begins offering the CalPERS Health Benefits Program.
- · Review health plan options due to changes in your marital status or enrollment area.
- · Explore health plan options because you are planning for retirement or have become Medicare eligible.

The Chooser takes you through five steps that provide you with key information about each health plan. At each step, you can rate the plans. When you finish, the Chooser gives you a Results Summary chart highlighting the plan(s) you rated as the best fit in each category. This chart allows you to easily determine which plan meets your needs.

Be sure to tell us what you think about the Health Plan Chooser by completing a survey located in the Chooser's "Results" page.

The Health Plan Chooser provides customized help in selecting the health plan that is right for you and your family. You can find the Health Plan Chooser by visiting CalPERS On-Line at www.calpers.ca.gov.

How to Use the Health Plan Chooser



Step 1. Estimate Your Costs

Your out-of-pocket costs will differ from plan to plan depending on several factors, including how much your employer contributes toward your premium, how often you go to the doctor, and how many prescriptions you fill each year. A chronic illness (e.g., heart disease, asthma, diabetes) can also affect your out-of-pocket costs. When you enter specific information about these variables into the Chooser, you will receive an estimate of how much your out-of-pocket costs will be each year. (Remember that any dollar amounts indicated on the Chooser are estimates only.)



Step 2. Find a Physician

Unless you moved recently, you probably already have a primary care physician. You can use the health plan links on the Chooser to see if your physician is in the health plan you are considering. If your physician is not in the plan you are considering or if you would like to change physicians, you can search for physicians in your area by name or by specialty.



Step 3. Review Member Ratings of Health Plans

The Chooser allows you to compare member ratings for the health plans. The member ratings indicate how other CalPERS members rate the plans. You can consider overall ratings as well as ratings in key areas, such as personal doctors, specialists, getting needed care, getting prescriptions easily, customer service, and accessing a plan's website.



Step 4. Evaluate Plan Features

On the surface, you may think that all health plans are pretty much the same — but if you look more closely, you will find differences in several areas. The Chooser helps you identify the differences by allowing you to evaluate features in three categories:

- Help to Stay Healthy
- Medical Conditions
- How to Save Money

For example, if you smoke and would like to guit, you can find out what type of smoking cessation program each plan offers. If your child has asthma, you can find out about asthma management programs. If you fill multiple prescriptions each year, you can get helpful tips on how to save money on your medications.



Step 5. Compare Plan Costs and Covered Services

This part of the Chooser provides a summary of your costs for doctor visits and hospital stays, deductibles (if applicable), and the yearly maximum for each plan. To see more detailed information about your cost for various services, select any of the plan names.

For more information about CalPERS health plans and access to the Health Plan Chooser, visit our website at www.calpers.ca.gov. To speak with someone at CalPERS about your health plan choices, call 888 CalPERS (or 888-225-7377).

Comparing Your Options: Health Plan Choice Worksheet

An alternative tool we provide to help you choose the best plan for yourself and your family is the Health Plan Choice Worksheet, which you can find on page 33 of this booklet. Like the Chooser, this worksheet can be used to compare factors such as cost, availability, benefits, and member ratings. Simply follow the steps listed in the left column of

the Worksheet. Several questions can be answered with a simple "yes" or "no," while others will require you to insert information or call the health plan. Some of the information can be found at CalPERS On-Line at www.calpers.ca.gov. If you need assistance completing the form, contact CalPERS at 888 CalPERS (or 888-225-7377).

Saving Money by Selecting a High-Performance Network

We want to help you get the most for your health plan dollars. One way you may be able to save on your health premium is by enrolling in one of our "highperformance network" plans. These plans — Blue Shield NetValue (HMO) and PERS Select (PPO) — provide the same benefits and quality of care as Blue Shield Access+ HMO and PERS Choice, respectively. The difference is that you pay a lower premium in exchange for choosing from a smaller selection of physicians and hospitals.

NetValue is available in 27 counties, and PERS Select is offered in 58 counties. If you don't reside in one of these counties, but you work in one, you may be able to enroll in a lower cost health plan using your work ZIP Code (see the "Health Plan Availability by County" chart on pages 6-7). You may also use our online service, the Health Plan Search by Zip Code, available at www.calpers.ca.gov.

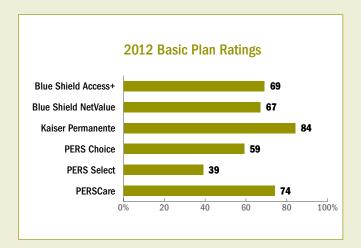
Reviewing Annual Health Plan Ratings

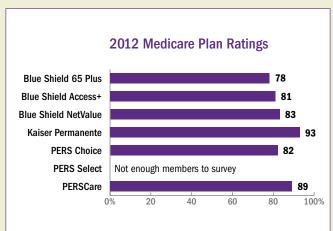
Every year, CalPERS conducts a survey of 1,100 members in each Basic and Medicare health plan that has at least 2.000 members.1 We use a modified version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, which is a standard tool for measuring health plans.

Reviewing how other CalPERS members rate their health plan can help you choose a plan that is right

for you. Please note that your experiences may differ depending on your needs, expectations, and behavior, as well as your provider and treatment choices.

The following charts show the percentage of members in each plan who rated their health plan an 8, 9, or 10 on a 10-point scale. The margin of error for the Basic plans is plus or minus about 5.2 percent; for the Medicare plans, it is plus or minus 3.6 percent.





Note: Since Association Plans (CCPOA, CAHP, and PORAC) are available only to members who belong to the applicable association, we did not include ratings for these plans.

Additional 2012 member ratings are available on CalPERS On-Line at www.calpers.ca.gov.

You can also find other important health plan rankings and health care tips on the Office of the Patient Advocate website at www.opa.ca.gov.

¹ This year, PERS Select did not have enough Medicare members to survey. For the smaller plans, the number of members surveyed represents a larger percentage of the total covered lives in those plans, resulting in a higher ratio of survey respondents to adult members served.

Additional Resources

As a health care consumer, you have access to many resources, services, and tools that can help you find the right health plan, doctor, medical group, and hospital for yourself and your family.

Health Plan Directory

Following is contact information for the health plans. Call your health plan with questions about: ID cards; verification of provider participation; service area boundaries (covered ZIP Codes); benefits, deductibles, limitations, exclusions; and Evidence of Coverage booklets.

Blue Shield of California

P.O. Box 272520, Chico, CA 95927-2520 Member Services: (800) 334-5847

65 Plus Member Services: (800) 776-4466

www.blueshieldca.com/calpers

California Association of Highway Patrolmen (CAHP) **Health Benefits Trust**

(Administered by Anthem Blue Cross) 2030 V Street, Sacramento, CA 95818-1730

For eligibility issues contact:

(800) 734-2247 or (916) 452-6751 (CAHP) info@thecahp.org

For benefits or claim information, contact:

Anthem Blue Cross, Attn: CAHP Unit P.O. Box 60007, Los Angeles, CA 90060-0007 (800) 759–5758 (Anthem Blue Cross) www.anthem.com/ca

California Correctional Peace Officers Association (CCPOA) Benefit Trust Fund

(Administered by Blue Shield of California and Express Scripts)

2515 Venture Oaks Way, Suite 200 Sacramento, CA 95833-4235

CCPOA Benefit Trust Fund:

(800) 468-6486

(800) 257-6213 (COBRA)

www.ccpoabtf.org

Blue Shield—CCPOA Member Services Unit:

(800) 257-6213

Kaiser Permanente

Member Services:

Call Center (800) 464-4000

www.kp.org/calpers to obtain facility mailing address

PERS Select, PERS Choice, and PERSCare **Medical Benefits:**

(Administered by Anthem Blue Cross) P.O. Box 60007, Los Angeles, CA 90060-0007 (877) PERS PPO or (877) 737-7776 (818) 234–5141 (outside of the continental U.S.)

TTY (818) 234-3547

For direct premium payments:

P.O. Box 629, Woodland Hills, CA 91365-0629 www.anthem.com/ca/calpers

Pharmacy Benefits:

(Administered by CVS Caremark) (877) 542-0284, TTY (800) 863-5488 www.caremark.com/calpers

Peace Officers Research Association of California

(PORAC) Health Plan (Administered by Anthem Blue Cross and Express Scripts)

For eligibility issues, contact:

4010 Truxel Road, Sacramento, CA 95834 (800) 655-6397 (PORAC)

www.porac.org

For benefits or claim information, contact:

Anthem Blue Cross, Attn: PORAC Unit P.O. Box 60007, Los Angeles, CA 90060-0007 (800) 288-6928

www.anthem.com/ca

Obtaining Health Care Quality Information

Following is a list of resources you can use to evaluate and select a doctor and hospital.

Source	Website	Description
Hospitals		
CalHospitalCompare	www.CalHospitalCompare.org	CalHospitalCompare is a standardized, universal performance report card for California hospitals that includes patient experience and clinical quality measures.
U.S. Department of Health and Human Services	www.hospitalcompare.hhs.gov	This site provides publicly-reported hospital quality information, including measures on heart attacks, pneumonia, heart failure, and surgery.
HealthGrades	www.healthgrades.com	HealthGrades uses data from Medicare and states to compare outcomes of care for common procedures.
The Leapfrog Group	www.leapfroggroup.org	This is a coalition of health purchasers who have found that hospitals meeting certain standards have better care results.
Doctors and Medical	Groups	
California Medical Board	www.medbd.ca.gov	This is the State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.
Office of the Patient Advocate	www.opa.ca.gov	This website includes a State of California-sponsored "Report Card" that contains additional clinical and member experience data on HMOs and medical groups in California.

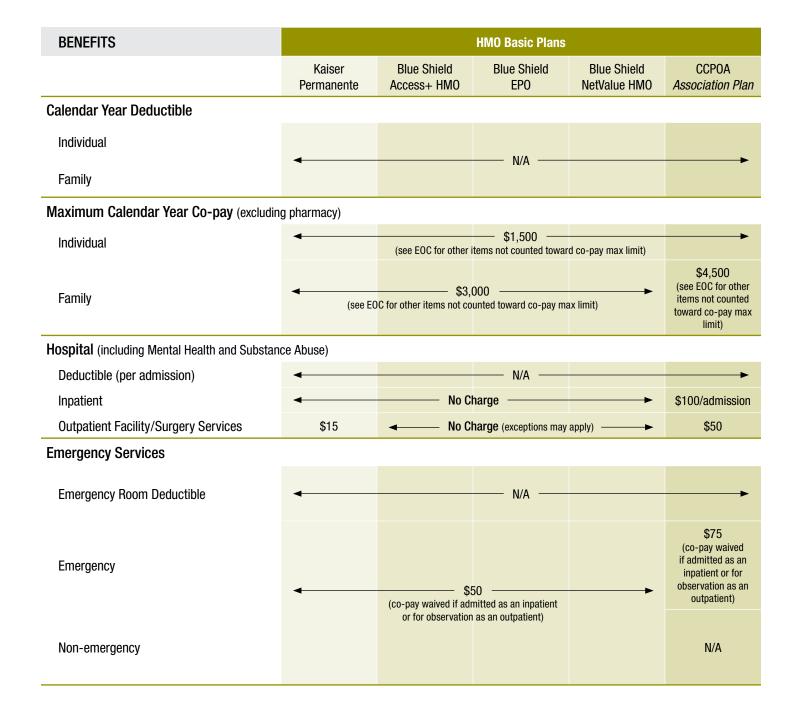
Benefit Comparison Charts

The benefit comparison charts on pages 14–31 summarize the benefit information for each health plan. For more details, see each plan's Evidence of Coverage (EOC) booklet.

CalPERS Basic Health Plans

Benefit Comparison Charts

Preventive services identified by the Patient Protection and Affordable Care Act (PPACA) are covered equally by all plans at no cost to you. Contact your physician or your health plan's customer service number for a list of these preventive services. For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.



				PPO Bas	sic Plans					
PERS S	Select	PERS	Choice	PERS	SCare	CAHP Asso	ciation Plan	PORAC Asse	ociation Plan	
PP0	Non-PPO	PP0	Non-PPO	PP0	Non-PPO	PP0	Non-PPO	PP0	Non-PPO	
•			00 ———— e between plans)			N	/A	\$300	\$600	
•			000 ———— e between plans)			IV.	/A	\$900	\$1,800	
\$3,000		\$3,000		\$2,000		\$2,000		\$3,	000	
\$6,000	N/A	\$6,000	N/A	\$4,000	N/A	\$4,000	N/A	\$6,000		
4	N	/A ———		\$2	250	•		A		
20–30% ¹ (hospital tiers)	40%	20%²	40%	10%²	40%	10%	Varies (see EOC)	10%	10%³	
deduc	(applie:	\$5 s to hospital emerg dmitted as an inpa	gency room charge	es only;		•	N/	/A ———	-	
200			20% 10% es such as physician, x-ray, lab, etc.)				\$50 + 10% (co-pay reduced to \$25 if admitted on an inpatient basis)	10	0%	
20% ← (payme	40% int for physician o	20% charges only; eme	40% rgency room facilit	10% y charge is not co	40% overed)	if admitted on an inpatient basis)	\$50 + 40% (co-pay reduced to \$25 if admitted on an inpatient basis)	(for non-e services provi	0% emergency ded by hospital acy room)	

BENEFITS			HMO Basic Plans		
	Kaiser Permanente	Blue Shield Access+ HMO	Blue Shield EPO	Blue Shield NetValue HMO	CCPOA Association Plan
Ambulance Services					
	•		— No Charge —		-
Physician Services (including Mental Health	and Substance Abus	se)			
Office Visits (co-pay for each service provided)	4		 \$15		-
Inpatient Visits	4		— No Charge —		-
Outpatient Visits	\$15 (outpatient surgery)	•		5 ———	-
Urgent Care Visits	•	\$	15 ———		\$15
Allergy Testing	\$15	•	No Ch	narge —	-
Allergy Treatment	No Charge (for allergy injections)	•	No Cr	narge ————	•
Vision Exam/Screening	No Charge	(may be lim	No Charge ited to one visit for age 1 ber of visits for member	18 and over;	\$15
Surgery/Anesthesia	No Charge inpatient; \$15 outpatient	•	No Ch	narge ————	-
Diagnostic X-Ray/Lab					
	(some procedures may require a co-pay)	•	No Cl	harge ————	-
Prescription Drugs					
Deductible	•	N	/A —————		Brand Formulary: \$50 (not to exceed \$150/family)
Retail Pharmacy	Generic: \$5 Brand: \$20 (not to exceed 30-day supply)		Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50 ot to exceed 30-day supp		Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$50 (not to exceed 30-day supply)
Medical Necessity/Partial Waiver	N/A	4	\$40	-	N/A

				PPO Ba	sic Plans				
PERS	Select	PERS	Choice	PER	SCare	CAHP Ass	ociation Plan	PORAC Asse	ociation Plan
PP0	Non-PPO	PP0	Non-PPO	PP0	Non-PPO	PP0	Non-PPO	PP0	Non-PP0
				2	0% ———				•
\$20 ¹		\$20 ²		\$20 ²		\$15		\$20	
20%1		20%²		10%²					10%³
						10%		10%	
\$20 ¹	40%	\$20 ²	40%	\$20 ²	40%	\$15	40%		
						ψ.0		1070	
20%¹		20% ²		10%²		10%			
				—— Not C	overed ———				
20%¹	40%	20%²	40%	10%²	40%	10%	40%	10%	10%³
20%	40%	20%	40%	10%	40%	10%	40%	10%	10%³
2070	4070	2070	4070	1070	4070	1070	4070	1070	1070
					J/A				
					47.1				
	Gener Preferre Non-Prefe (not to exceed :	ed: \$20 erred: \$50		Prefer Non-Pref	eric: \$5 red: \$20 erred: \$50 34-day supply)	Single S Multi Sc	eric: \$5 ource: \$20 ource: \$25 I 30-day supply)	Generic: \$10 Brand Formulary: \$25 Non- Formulary: \$45 Compound: \$45	Generic: \$ Brand Formulary \$25 Non- Formulary \$45 Compound Not Covere (see EOC)
			40 _				N.	I/A	
		\$	40 ———		-	—	N	I/A ———	

BENEFITS			HMO Basic Plans		
	Kaiser Permanente	Blue Shield Access+ HMO	Blue Shield EPO	Blue Shield NetValue HMO	CCPOA Association Plan
Prescription Drugs (continued)					
Retail Pharmacy Maintenance Medications filled after 2 nd fill (i.e., a medication taken longer than 60 days)	N/A		Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100 ot to exceed 30-day supp		Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$50 (not to exceed 30-day supply)
Medical Necessity/Partial Waiver		•	\$70	-	N/A
Mail Order Pharmacy Program	Generic: \$5 Brand: \$20 (up to 30-day supply) Generic: \$10 Brand: \$40 (31-100 day supply)		Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100 not to exceed 90-day sup for maintenance drugs)		Generic: \$20 Brand Formulary: \$50 Non-Formulary: \$100 (not to exceed 90-day supply)
Medical Necessity/Partial Waiver Maximum co-payment per person per calendar year	N/A	←	\$70	→	N/A
Durable Medical Equipment					
	•		No Charge		
Infertility Testing/Treatment					
	4	50% (of covered charges (se	ee EOC)	-
Home Health Services (prior authorization	required; custodial ca	are not covered)			
	•	No C	Charge ————	-	\$15 (up to 100 visits/ calendar year)

				PPO Bas	sic Plans				
PERS	Select	PERS	Choice	PERS	SCare	CAHP Asso	ciation Plan	PORAC Asso	ciation Plan
PP0	Non-PPO	PP0	Non-PP0	PP0	Non-PPO	PP0	Non-PPO	PP0	Non-PP0
•	Preferr Non-Prefe	ic: \$10 ed: \$40 rred: \$100 30-day supply)		Preferi Non-Prefe	ric: \$10 red: \$40 erred: \$100 34-day supply)	Single So Multi So	ric: \$10 Durce: \$40 urce: \$50 30-day supply)	N/	'A
•		\$	70 ———		-	4	N	I/A ———	•
•	Generic: \$10 ————————————————————————————————————				Single So Multi So	ric: \$10 Durce: \$40 urce: \$50 90-day supply)	Generic: \$20 Brand Formulary: \$40 Non- Formulary: \$75 (see EOC for specialty pharmacy fees)	N/A	
			70 ————————————————————————————————————			•	N	I/A	
20%	40% —— (pre-certifi	20% ication required fo	40% r equipment \$1,00	10% 0 or more) ——	40%	10%	40%	20%	20%³
			——— Not Co	overed ———				50	%
20%	40% — (up to 45 visits	20% s/calendar year) —	40%	10% (up to 100 visit	40% s/calendar year)	10% (up to 90 visits/p	40% period of disability)	10 (up to 100 visits, benefit for PF	/year; combin

BENEFITS	HMO Basic Plans								
	Kaiser Permanente	Blue Shield Access+ HMO	Blue Shield EPO	Blue Shield NetValue HMO	CCPOA Association Plan				
Skilled Nursing Care									
Inpatient (hospital or skilled nursing facility)	No Charge (up to 100 days/ benefit period)	•	No C l (up to 100 days	harge oʻ/calendar year)	•				
Outpatient (office and home visits)	4		— Not Covered —		-				
Occupational / Physical / Speech Thera	ру								
Inpatient (hospital or skilled nursing facility)	•		— No Charge —		-				
Outpatient (office and home visits)	•		15 ————		No Charge				
Hospice									
	•		No Charge —						
Acupuncture									
	\$15 (when medically necessary; discounts available – see EOC)	4		overed ———————————————————————————————————	-				
Chiropractic									
	4		overed ———————————————————————————————————	-	\$15 exam (up to 20 visits) No Charge diagnostic services; chiropractic appliances (up to \$50)				

				PPO Bas	sic Plans					
PERS	Select	PERS	Choice	PERS	Care	CAHP Asso	ciation Plan	PORAC Association Plan		
PP0	Non-PPO	PP0	Non-PPO	PP0	Non-PPO	PP0	Non-PPO	PP0	Non-PPO	
20% first 10 days; 30% next 90 days	40% (pre-certifica up to 100 days		40% ►		40% first 10 days; 40% next 170 days tion required; /calendar year)	10% (up to 100 days	40% s/benefit period)	10 (up to 100 combined skilled nurs	days/year benefit for	
•		——— Not Co	overed ———			•	N	I/A ————		
4		——— No Cl	narge ———		-			10%	10%³	
20% ← (pre-c	40%; Occupational therapy: 20% certification require	20% d for more than 24	40%; Occupational therapy: 20% visits)	20			40% ation required an 24 visits)	\$20	10%³	
4	20	% ———	→	10)%	No C	harge	10	%	
20% ← (acu	40% puncture/chiroprac	40% tic; combined 15	40% visits) —	10% ← (acup	40% ouncture/chiroprad	10% ctic; combined 20	40% visits) ──►	\$20 (10% for all other services)	10%³	
20% ← (acu	40% puncture/chiroprac	20% tic; combined 15 ^v	40% visits) ——►	10% ◄ (acup	40% ouncture/chiroprad	10% ctic; combined 20	40% visits) ——►	Up to 20 visits (see EOC)	\$35/visit (see EOC)	

CalPERS Basic Health Plans — Continued

BENEFITS	HMO Basic Plans				
	Kaiser Permanente	Blue Shield Access+ HMO	Blue Shield EPO	Blue Shield NetValue HMO	CCPOA Association Plan
Hearing Aid Services					
Hearing Exam/Screening	•		— No Charge —		-
Audiological Exam	•	No C	harge —		\$15
Hearing Aids	•	\$1,000 max ev	very 36 months —	-	\$500 max/ member

	PPO Basic Plans										
PERS	Select	PERS	Choice	Care	CAHP Asso	ciation Plan	PORAC Association Plan				
PP0	Non-PPO	PP0	Non-PPO	PPO Non-PPO		PP0	Non-PPO	PP0	Non-PPO		
20%1		20%²		10%²				20%	20%³		
20%	40%	20%	40%	10%	40%	40%	10%	40%		0% luctible)	
20%	40% (one	20% single hearing de	40% vice every 36 mor	10%	40%	(one single he every 36		(no deductible;)% one hearing aid y 36 months)		

- ¹ PERS Select utilizes the Anthem Blue Cross Select PPO Network, which is a subset of the Anthem Blue Cross Prudent Buyer PPO Network. Approximately 50 percent of the Anthem Blue Cross Prudent Buyer PPO Network of physicians participate in the Select PPO Network. By obtaining physician services through the Select PPO Network, you will receive the highest level of reimbursement. If you are a PERS Select member, you should check to see if a physician is participating in the Select PPO Network before receiving services.
- ² PERS Choice and PERSCare utilize the Anthem Blue Cross Prudent Buyer PPO Network, which is a more comprehensive network. By obtaining services through Anthem Blue Cross Prudent Buyer PPO Network, you will receive the highest level of reimbursement.
- ³ Covered expense for services from non-PPO providers is based on a strictly limited schedule of allowances. As a PPO member, you must pay charges in excess of those scheduled amounts.

CalPERS Medicare Health Plans

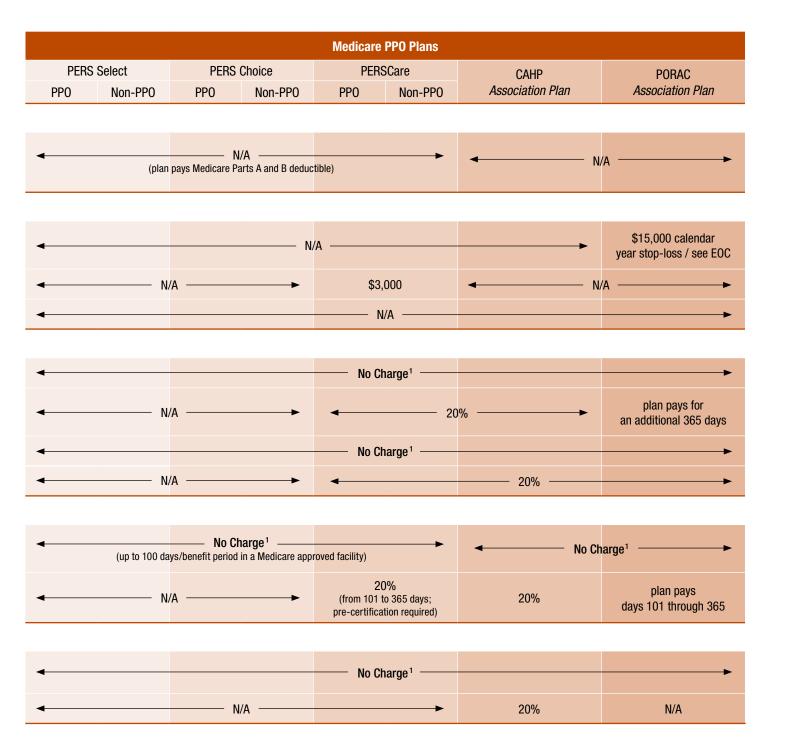
Benefit Comparison Charts

Preventive services identified by the Patient Protection and Affordable Care Act (PPACA) are covered equally by all plans at no cost to you. Contact your physician or your health plan's customer service number for a list of these preventive services. For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

BENEFITS		Medicare HMO Plans						
	Kaiser Permanente	Blue Shield NetValue/Access+/EPO	Blue Shield 65 Plus	CCPOA Association Plan				
Calendar Year Deductible								
Individual	4	N	/A					
Family		IV.	/A					
Maximum Calendar Year Co-pay (exclud	ding pharmacy)							
Individual	\$1,500 (see EOC)	◄ N.	/A —	\$1,500				
Benefit Beyond Medicare	•	N	/A ————					
Family	\$3,000 (see EOC)	◄ N.	/A ——	\$4,500 (3 or more)				
Hospital (including Mental Health and Subst	ance Abuse)							
Inpatient	•	No Charge	-	\$100/admission				
Benefit Beyond Medicare	•	N	/A ————————————————————————————————————	-				
Outpatient Facility/Surgery Services	\$10	•	No Charge	-				
Benefit Beyond Medicare	•	N	/A ————					
Skilled Nursing Facility Care								
Medicare	•	(up to 100 days	harge s/benefit period)	-				
Benefit Beyond Medicare	◀	N	/A	-				
Home Health Services								
Medicare	•	No Charge ——	-	\$15 (up to 100 visits)				
Benefit Beyond Medicare	4	N	/A ————	-				

CalPERS offers several health plans that supplement your Medicare coverage. The primary payer is Medicare, and the CalPERS supplemental plan would be the secondary payer. The CalPERS supplemental plan will pay for benefits that are defined as covered services under Medicare.*

* The Centers for Medicare & Medicaid Services (CMS) regulates the Medicare program. CMS publishes the booklet, Medicare & You, which provides general information about Medicare. Please refer to Medicare & You if you have any questions regarding covered services. You can view or download this publication at www.medicare.gov.



CalPERS Medicare Health Plans — Continued

BENEFITS		Medicare HMO Plans							
	Kaiser Permanente	Blue Shield NetValue/Access+/EPO	Blue Shield 65 Plus	CCPOA Association Plan					
Hospice									
Medicare	◀	No Cha	rge —						
Benefit Beyond Medicare	•	N/A							
Emergency Services									
Medicare	◄ \$50 (v	vaived if admitted or kept for obser	vation) —	No Charge					
Benefit Beyond Medicare	•	N/A							
Ambulance Services									
Medicare	•	No Cha	rge —						
Benefit Beyond Medicare	4	N/A	N/A						
Surgery/Anesthesia									
	No Charge inpatient; \$10 outpatient	•	— No Charge ——						
Physician Services (including Mental	Health and Substance Abuse)								
Office Visits	4	\$10							
Inpatient Visits	4	No Cha	rge —						
Outpatient Visits		•	— No Charge ——						
Urgent Care Visits	\$10	◄ \$25		\$10					
Allergy Testing	•	\$10							
Allergy Treatment	\$3 (for allergy injections)	◄ \$10		No Charge					
Diagnostic X-Ray/Lab									
	•	No Cha	rge —						
Durable Medical Equipment									
Medicare	4	No Cha	rge —						
Benefit Beyond Medicare	4	N/A							

				Medicare	PPO Plans		
PERS PP0	Select Non-PPO	PERS PP0	Choice Non-PPO	PERS PPO	SCare Non-PPO	CAHP Association Plan	PORAC Association Plan
110	NOIT I TO	110	Non ii	110	Non ii	7.00001011077 7.1007	7.0000,000,000
•				—— No Ch	narge ¹ ———		-
•		N	/A —	-		20% (see EOC)	N/A
•				No Ch	narge ¹		-
•		N	/A ———			20% (see EOC)	N/A
•				—— No Ch	narge ¹		-
•		N	/A			20% (see EOC)	N/A
				N. OI	1		
				—— NO Cr	narge ¹ ———		
						\$10	No Charge
•		——— No Ci	narge ¹ ———		→	◆ No Ch	arge¹ —
•				—— No Ch	narge ¹ ———		-
•				No Ch	narge ¹		-
•		N	/A —		-	→ 20	% —

BENEFITS		Medicare HMO Plans							
	Kaiser Permanente	Blue Shield NetValue/Access+/EPO	Blue Shield 65 Plus	CCPOA Association Plan					
Prescription Drugs									
Deductible	•	N	/A ————	-					
Retail Pharmacy	Generic: \$5 Brand: \$20 (not to exceed 30-day supply)	Brand Form Non-Form	ric: \$5 nulary: \$20	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$35 (not to exceed 30-day supply)					
Medical Necessity/Partial Waiver		\$40	← N	//A ——▶					
Retail Pharmacy Maintenance Medications filled after 2 nd fill (i.e., a medication taken longer than 60 days)	N/A	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100 (not to exceed 30-day supply)	N/A	Generic: \$5 Brand Formulary: \$26 Non-Formulary: \$35 (not to exceed 30-day supply)					
Medical Necessity/Partial Waiver		\$70	▼ • • • • • • • • • • • • • • • • • • •	//A —— ►					
Mail Order Pharmacy Program	Generic: \$5 Brand: \$20 (not to exceed 30-day supply) Generic: \$10 Brand: \$40 (31-100 day supply)	Brand Form	ic: \$10 nulary: \$40	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$70 (not to exceed 30-day supply)					
Medical Necessity/Partial Waiver		\$70	N/A						
Maximum co-payment per person/ calendar year	N/A	\$1,000	(see EOC)	N/A					
Occupational / Physical / Speech Ther	ару								
Inpatient (hospital or skilled nursing facility)	No Charge	\$10	No Charge	No Charge					
Outpatient (office and home visits)	•	\$10	-						
Benefit Beyond Medicare (inpatient/outpatient)	•	N	/A ————————————————————————————————————	-					
Diabetes Services									
Glucose monitors, test strips	•	No Charge	e (see EOC)	-					
Self-management training	No Charge	\$10 (includes nutritional counseling)	← \$	10					
Benefit Beyond Medicare	4	N	/A ————	•					

		Medicare PPO Plans		
PERS Select	PERS Choice	PERSCare	CAHP	PORAC
PPO Non-PPO	PPO Non-PPO	PPO Non-PPO	Association Plan	Association Plan
•	N	/A ————————————————————————————————————	-	\$100 (excludes mail order)
•	Generic: \$5 Preferred: \$20 Non-Preferred: \$50	-	Generic: \$5 Single Source: \$20 Multi Source: \$25 (not to exceed 30-day supply)	Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$45
•	\$40	-	→ N/	/A —
✓ Preferi Non-Preferi	ric: \$10 red: \$40 erred: \$100 30-day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 34-day supply)	Generic: \$10 Single Source: \$40 Multi Source: \$50 (not to exceed 30-day supply)	N/A
•	\$70	-	← N/	/A ———
•	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 90-day supply)	-	Generic: \$10 Single Source: \$40 Multi Source: \$50 (not to exceed 90-day supply)	Generic: \$20 Brand Formulary: \$40 Non-Formulary: \$75
•	\$70 \$70 \$1,000 (see EOC) \$	*	← N	/A ——▶
•		——— No Charge ¹ ———		-
← N	I/A — →	•	20% —	-
•		No Charge 1		-
4	N	/A ————————————————————————————————————	-	20%

BENEFITS	Medicare HMO Plans							
	Kaiser Permanente	Blue Shield NetValue/Access+/EPO	Blue Shield 65 Plus	CCPOA Association Plan				
Hearing Services								
Hearing Exam	•	\$10	-	No Charge				
Audiological Exam	\$10	→ No Ch	harge	\$15				
Benefit Beyond Medicare	•	N	/A	-				
Hearing Aids – Benefit Beyond Medicare	•	\$1,000 max/36 months		\$500 max/member				
Vision Care								
Vision Exam	\$10	◆ \$10 (limited to o	ne visit/see EOC)	\$10				
Benefit Beyond Medicare	•	N	/A ————	-				
Eyeglasses	•	No Charge following	ng cataract surgery ——					
Benefit Beyond Medicare	•	N	/A ————	-				
Contact Lenses	•	No Charge following	ng cataract surgery ——					
Benefit Beyond Medicare	In lieu of eyeglasses: \$175 allowance every 24 months	•	N/A					
More Benefits Beyond Medicare (Services	s covered beyond Medica	re coverage)						
Acupuncture	\$10 (when medically necessary; discounts available/see EOC)	•	N/A	-				
Chiropractic	\$10 (20 visits; discounts available/see EOC) No Charge chiropractic appliances (\$50 max)	← \$1	10	\$15/exam (up to 20 visits) No Charge diagnostic services; chiropractic appliances (\$50 max)				
Smoking Cessation Program	•	N	/A ————————————————————————————————————	*				

Medicare PPO Plans									
	S Select	PERS (PERS		CAHP	PORAC		
PP0	Non-PPO	PP0	Non-PPO	PP0	Non-PPO	Association Plan	Association Plan		
•		No Ch	arge ¹			No Charge	20%		
•				No Ch	arge¹ ———				
•		20	% ———			10% (\$200 max/36 months)	20% (up to \$50/exam in connection with hearing aid purchase)		
•	(\$1,000 max	2/36 months)		20 (\$2,000 max	% 2/24 months)	10% (\$1,000 max/36 months)	20% (\$450 max/36 months/one ear)		
•				N	/Α ———				
•		— One exam				N/A	20% (limit one exam)		
•			No	Charge followin	ng cataract surg	gery —	-		
Tw	o lenses/calenda Se	r year; one set c ee EOC for maxi	of frames during mum allowance	a 24-month poes	eriod	N/A	20% (\$40 combined max for initial frames and lenses)		
•			No	Charge following	ng cataract surg	gery ————	-		
•		 \$100	max —			N/A	20% (up to \$40)		
←	N	/A		20 (up to 2					
4		No Ch	arge ¹			20	D% —		
4		20% (\$1	00 max) ———		-	No Charge (\$100 max)	N/A		

If benefits are payable by Medicare and you use a provider who accepts Medicare assignment, covered services will be paid in full.

Notes	

Health Plan Choice Worksheet

	Plan name and phone numbers:								
	Select the type of plan: (circle choice)	PP0	нмо	EP0	Assoc. Plan¹	PP0	нмо	EP0	Assoc. Plan ¹
St	Calculate your monthly cost. Enter the monthly premium (see current year's rate schedule). Premium amounts will vary based on 1-party/2-party/family and Basic/Medicare.								
Step 1 - Cost	Enter your employer's contribution. For contribution amounts, active members should contact their employer; retired members should contact CalPERS.								
) 21	Calculate your cost. Subtract your employer's contribution from the monthly premium. If the total is \$0 or less, your cost is \$0.								
Step 2 - Availability	Search available plans online. Use our online service, the Health Plan Search Zip Code, at www.calpers.ca.gov to find out if the plan is available in your residential or work ZIP code. You may also call the plan's customer service center.								
vailability	Call the doctor's office. Confirm that they contract with the plan and are accepting new patients. Ask what specialists are available and the hospitals with which they are affiliated.								
Step 3	How did the plan rate in "satisfaction"? See page 11 to find out.								
- Comparisons	Compare the "benefits." See pages 14–31. CalPERS plans offer a standard package of benefits, but there are some differences: acupuncture, chiropractic, etc.								
Step .	Other considerations: Does the plan offer health education? Do you or your family have special medical needs? What services are available when you travel? Are the provider locations convenient?								
Step 4 - Other	What changes are you planning in the upcoming year (e.g., retirement, transfer, move, etc.)?								
	Other information								
	Compare and select a plan.								

 $^{^{1}}$ You must belong to the specific employee association and pay applicable dues to enroll in the Association Plans.



CalPERS Health Benefits Program
P.O. Box 942714
Sacramento, CA 94229-2714
888 CalPERS (or 888-225-7377)
www.calpers.ca.gov

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NOTICE OF RIGHT TO CONTINUE COVERAGE UNDER COBRA

VERY IMPORTANT NOTICE

On April 7, 1986, a Federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. (Both you and your spouse should take the time to read this notice carefully.)

If you are an employee of Foothill-De Anza Community College District (FDCCD) covered by FDCCD Group Health Plan, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by Foothill-De Anza Community College District, you have the right to choose continuation coverage for yourself if you lose group health coverage under FDCCD Group Health Plan for any of the following four reasons:

- 1. The death of your spouse;
- 2. A termination of your spouse's employment or reduction in your spouse's hours of employment (for reasons other than gross misconduct);
- 3. Divorce or legal separation from your spouse; or
- 4. Your spouse becomes entitled (that is, covered) under Medicare.

In the case of a dependent-child of an employee covered by FDCCD Group Health Plan, he or she has the right to continuation coverage if group health coverage under FDCCD Group Health Plan is lost for any of the following five reasons:

- 1. The death of a parent;
- 2. A termination of a parent's employment or reduction in a parent's hours of employment with the FDCCD (for reasons other than gross misconduct);
- 3. Parent's divorce or legal separation;
- 4. A parent becomes entitled (that is, covered) under Medicare; or
- 5. The dependent ceases to be a "dependent child" under FDCCD Group Health Plan.

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator, Foothill-De Anza Community College District, of a divorce, legal separation, or a child losing dependent status under FDCCD Group Health Plan within <u>60 days</u> of the date of the event or the date on which coverage would end due to the event, whichever is later. The District has the responsibility to notify the various Plan Administrators of the employee's death, termination of employment, reduction in hours or Medicare eligibility.

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the FDCCD Group Health Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the District's Human Resources Office of the birth or adoption.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; The District reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you may have to pay all or part of the premium for your continuation coverage. You will have a grace period of at least 30 days to pay the premium due. When continuation coverage ends, you must be allowed to enroll in an individual conversion health plan if a conversion option is offered by the FDCCD Group Health Plan.

If you have any questions regarding COBRA, a change in marital status, or you or your spouse have changed addresses, please notify:

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT ATTN: CHRISTINE VO, HR DEPT. 12345 EL MONTE RD LOS ALTOS HILLS, CA 94022

> TELEPHONE: (650) 949-6225 FAX: (650) 949-2831 E-MAIL: VoChristine@fhda.edu



To: Employees Covered by District Benefits and their Spouses and

Dependents

From: Christine Vo

Benefits Manager

RE: General C.O.B.R.A. Information

The information contained in this letter pertains to a Federal law regarding continuation of medical benefits. It is important that you and your family members read this letter carefully and keep it for future reference.

Notice of Right to Continue Coverage (C.O.B.R.A.)

On April 7, 1986, a Federal law, <u>Consolidated Omnibus Budget Reconciliation Act</u>, was enacted (Public Law 99-272, Title X, known as **C.O.B.R.A.**) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you in a summary fashion, of your rights and obligations under the **continuation coverage** provisions of this law.

If you are an employee of the Foothill-De Anza Community College District covered by the District's Group Health Plans (Kaiser-HMO or District Self-Insured Medical Plan, Prescription Drug, Dental and Vision Care), you have a right to choose continuation coverage if you lose these group health coverage because of a reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the District's Group Health Plans, you have the right to choose **continuation coverage** for yourself if you lose group health coverage under the Group Health Plans for any of the following four reasons:

- 1. The death of your spouse;
- 2. The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
- 3. Divorce or legal separation from your spouse; or

4. Your spouse becomes eligible for Medicare.

In the case of a dependent child of an employee covered by the District's Group Health Plans, he or she has the right to **continuation coverage** if group health coverage under the District's Group Health Plans is lost for any of the following five reasons:

- 1. The death of a parent;
- 2. The termination of a parent's employment (for reason other than gross misconduct) or reduction in a parent's hours of employment with the Foothill-De Anza Community College District;
- 3. Parents divorce or legal separation;
- 4. A parent becomes eligible for Medicare; or
- 5. The dependent ceases to be a "dependent child" under the District's Group Health Plans.

Under the law, the employee or a family member has the responsibility to inform the Foothill-De Anza Community College District of a divorce, legal separation, or a child losing dependent status under the District's Group Health Plans within <u>60 days</u> of the date the event occurred. The Foothill-De Anza Community College District has the responsibility to notify the various Plan Administrators of the employee's death, termination of employment, reduction in hours or Medicare eligibility.

When the Foothill-De Anza Community College District is notified that one of these events has happened, the Foothill-De Anza Community College District will notify you that you have the right to choose **continuation coverage**. You have at least <u>60 days</u> from the date you would lose coverage, because of one of the events described above, to inform the Foothill-De Anza Community College District that you want **continuation coverage**. If you do not choose **continuation coverage**, your group health insurance coverage will end.

If you choose **continuation coverage**, Foothill-De Anza Community College District is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain **continuation coverage** for <u>36 months</u> unless you lose group health coverage because of a termination of employment or reduction in hours. In that case, the required **continuation coverage** period is <u>18 months</u>. However, the law also provides that your **continuation coverage** may be cut short for any of the following five reasons:

1. Foothill-De Anza Community College District no longer provides group health coverage to any of its employees;

- 2. The premium for your **continuation coverage** is not paid;
- 3. You become an employee covered under another group health plan, unless excluded by a pre-existing condition;
- 4. You become eligible for Medicare;
- 5. You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's group health plan.

You do not have to show that you are insurable to choose **continuation coverage**. However, you must pay the premium for your **continuation coverage**. (The law also says that, at the end of the <u>18 month</u> or <u>36 month</u> continuation period, you may enroll in an individual conversion medical plan provided under Kaiser-HMO or ReliaStar (formerly NWNL). Currently, there is no individual conversion plan available for either the dental or vision care plans.

This law applies to the District Health Plans since January 1, 1987.

If you have any questions, please contact Christine Vo, Benefits Manager, at 650-949-6225 or via e-mail: <u>VoChristine@fhda.edu</u>.



Universal Enrollment Form

Medical/Dental/Vision - For Active, Retiree, COBRA, Surviving Spouse Participants

OFF	ICE USE ONLY: Plan Type	_ Plan	Code	Co	verage	Code	_ Effective	e Date
Med	ical Regional Code:	(Ba	ay Area; Sacrame	ento; No. CA; Los Angeles; So. CA; Out-of-State)				
Reti	ree Annuity Status: PERS ID:					STRS ID:		
	•							
Pla	n Selection:						Т	
🗏 E	Blue Shield Access+ HMO Blue Shield NetValue HMO Kaiser Permanente HMO		PERS Select P PERS Choice F PERS Care PP	PO (Anthem	n Blue Cross)	_	n Dental of California on Service Plan (VSP)
	ployee Information:		T					I =
Nan	ne (Last, First, M.I.)		Social Securit	y Nun	nber	Date of Birth		Hire Date
Phy	sical Home Address (NO P.O. Box)				Home	Phone:		
,						native Phone:		
Sex			1					
	Female		Divorced	_l Mar	ried	☐ Legal Separ	ation	
Hrs	worked per week: Date of N		e/Partnership:			Campus Loca	tion:	
☐ F	ssification: T Faculty	☐ Co	onfidential 🗌 S	Superv		☐ Classified /	ACE	Administrator
Classified CSEA □ Board Member □ Retiree □ Surv. Spouse □ OE3 □ COBRA Enrollee MEDICAL □ Employee Only Employee + Spouse □ Employee + Spouse □ Employee + Same-Sex Domestic Partner (DP/CA Reg) □ Employee + Same-Sex Domestic Partner						Partner (DP/CA Reg) Partner (DP/Non-Reg) Child(ren) Child(ren) s Child(ren)		
	This Election is for: New Enrollment Marriage/Divorce: Effective date Name Change: Former name				Termina Change Death c	ation of Employment of Subscriber or legal separat	nent Hours	ng Event Date:

□ Birth of Child □ Dependent reached age limit according to PLAN □ Adoption or Placement of Adoption (Court Ordered □ Retirement (when ineligible for District paid benefits)									
	Coverage: Please attach a copy of court order) Medical / Dental / Vision Coverage:								
(A)dd (C)hange (D)elete	Relationship	Name (Last, F	irst, M.I.)	Social Security Number	Date of Birth	Gender	Disabled?		
	☐ Spouse ☐ Domestic Partner								
	Daughter/Son								
	Daughter/Son								
	Daughter/Son								
If no, your cl	Do your children reside with you? ☐ YES ☐ NO If no, your children's physical address is :								
Do you or			1	alth coverage? If yes, p	•				
	N	lame	Na	me and address of other ins	urance Carrier	Effe	ective Date		
Self									
Spouse/DP									
Daughter/Son									
Daughter/Son									
Daughter/Son									
Medicare S	Section:			1					
If Yes Pa	ed?	No		If yes for Medicare for y provide your and/or thei and Medicare eligibility	r SSN and indicat	e the entitle	ment reason		
If yes, for you Pa	ur dependents ha lo ur dependents art A Yes art B Yes Medicare Depend	No No		Retiree: SSN # Entitlement Reason: Over 65 Disabled OTHER Effective Date of Medicare/ Dependent(s): SSN # Name Entitlement Reason: Over 65 Disabled OTHER Effective Date of Medicare/					

Payroll Deduction Contributions

The plan administrator may reduce or cancel the amount of my payroll deduction contributions or otherwise modify this agreement if this becomes necessary to satisfy certain provisions of the Internal Revenue Code. The amount of my monthly payroll deduction contributions is shown on a schedule that has been provided to me and the amount may change in the future.

HMO Arbitration Agreement

I apply for Health Plan membership for myself and my covered family dependents. We agree to abide by the provisions of the Service Agreement and Health Plan policies. We understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between me, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

PPO Arbitration Agreement:

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

Your Authorization:

I acknowledge that I have received and read the enrollment materials for the Employee Benefits Program and I have read the information on this form. I acknowledge that the information submitted represents my enrollment choice(s) and I am authorizing contributions to be withheld from my pay for the healthcare covered selected.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Active employees only: I understand that any premiums I am obligated to pay for health care coverage for myself and/or any of my dependents will be deducted from my pay on a PRE-TAX basis.



Office of Employer and Member Health Services PO Box 942714 Sacramento, CA 94229-2714 Toll Free: (888) CalPERS (225-7377) Fax: (916) 795-1313 Telecommunications Device for the Deaf: (916) 795-3240

Declaration of Health Coverage: HBD-12A		(INSTRUCTIONS ON REVER			
EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER	NAME	(FIRST)	(MIDDLE)	(LAST)	
PART A I elect to enroll myself and all eligible dependents.					
PART B-1 I elect to enroll myself. My eligible dependents have other health insurance cover PART B-2 I elect to enroll myself and eligible dependents. I also have eligible dependents w		coverage, you can Benefits Program. 60 days from the c If you do not requ you or your deper	endents lose health insurance enroll in the CalPERS Health You must request enrollment late you lose coverage. uest enrollment within 60 dandents must wait at least 90 Open Enrollment Period bef	t within ys, days	
PART C-1 I decline enrollment for myself and my eligible dependents because we have other he insurance coverage.	alth	you can enroll in date of coverage	the Program. Your effectiv will be the first of the month lay waiting period or the Op	e I	
PART C-2 I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.		dependents at any days after you recopen Enrollment the Program. Yo be the first of the	time. You must wait at leas quest enrollment or until the period before you can enro ur effective date of coverage month following the 90 day the Open Enrollment effect	t 90 e next ll in e will	
PART B: If you are currently enrolled in the a court orders health coverage for your dependence of the period of the coverage for your dependence of the period of the coverage for your personnel of the period of	dents, you ca	an add your new dep	[2] (1) (1) (1) (1) [2] (1) (2) [2] (2) (2) [2] (2) (2) [2] (2) (2) (2) [2] (2) (2) (2) (2) (2) (2) (2) (2) (2) (2)	r if	
PART C: If you are not currently enrolled as a result of marriage, birth, adoption, or placed dependents, you can enroll yourself and dependents for applicable time limits.	ement for a	doption, or if a court	orders health coverage for yo	our	
Special rules apply to retirement and death	. Please re	ad the back of this f	form carefully.		
Member's Signature Date	Signed		Health Benefits Of	ficer's Signature	
Rev (3/09) Origi	nal: Employee	's Personnel File	Copy: Employee		

INSTRUCTIONS - DECLARATION OF HEALTH COVERAGE (HB-12A)

Please contact	your Health Benefits Officer if you have any questions regarding the HB-12A
Employee Information	Complete with the appropriate employee information.
PART A:	Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program.
PART B-1: PART B-2:	 Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage. Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
PART C-1:	 Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage. Mark this box if you are:
	 a) Declining enrollment or canceling your health insurance coverage for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include marriage, acquisition of a dependent child, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

Special rules for retirement and death:

Consider these points as you decided whether to enroll, decline, or cancel enrollment for yourself or dependents.

- If you are not eligible to be enrolled in a CalPERS-sponsored health plan on the date you separate employement, you will not be eligible for health benefits into retirement.
- If your retirement date is over 120 days from your separation date, you will not be eligible for health benefits into retirement.
- If you die and your eligible family members are enrolled on your CalPERS-sponsored health plan at this time, they may be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.



California Public Employees' Retirement System P.O. Box 942714 Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN

ENROLLMENT FORM DO NOT SEND MEDICAL PERS-HBD-12 (Rev.8/10) CLAIMS TO THIS ADDRESS						CalPE	RS II SE	ONI V	- DOCUM	ENT E	FEED	ENC	E NUMBER	,		
F LNS-HBD-12 (Nev.	OTTO) CLAIN	10 11110	י אטטו	PLEA	SE T	YPE	→	THE COL	ONLI	DOGGIII				LITOMBLI	<u> </u>	
1. TYPE OF ACTION (Check One)	2. SOCIAL SE	CURITY NUM	IBER			A C C T O I D O E	LIST ALL TO BE EI			uding sel	f) [ATE (Family Relation- ship	G E N D	CODE
☐ a. NEW enrollment☐ b. CHANGE of coverag☐ c. CANCEL all coverag	·	ESTIC PARTNI	ER'S SOC	CIAL SECURIT	ΓΥ –	N	17. BASI		(MI)	(LAST	Mc	Day	Yr.	SELF	M	F E
															4	+
4A. Name							SSN									
Mailing (FIRST) Address	(MI)			(LAST)			(FIRST)	(MI)	(LAST)					
City, State, ZIP		Daytime Phone	Ev	ening Phone			SSN									
4B. RESIDENCE ZIP C	ODE (If different fr	rom 4A)					(FIRST)	(MI)	(LAST)					
5. Please check if Permanent Intermittent Employee (applies to acti	6. GENDER	7.	MARRIE MYes	ΞD			SSN									
State employees only)	Female	•	☐ No				(FIRST)	(MI)	(LAST)					
8. PLAN CODE	9. NAME OF	HEALTH PLA	١N				SSN									
10. GROSS PREMIUM \$	11. PRIMARY C	ARE PHYSICIA	AN/MEDIC	CAL GROUP												
12. PRIOR PLAN CODE 13. PRIOR HEALTH PLAN					A C C	18. SUPPLE				_	ATE OF B	IRTH	Relation-		C O D E	
14. Reason Code 15. Permitting Event Date 16		16 EEE	S EFFECTIVE DATE		T O I D O E	(FIRST)	(MI)	(LAST) Mo	Day	Yr.	ship		E	
14. Neason Code	Mo. Da		Mo.	Day Y	Yr.	N										\pm
19. CHECK ONE I DO NOT elect to en I elect to ENROLL IN salary or retirement al all dependents listed a	(OR CHANGE TO) a lowance to cover my above in items 17 and	Health Benefits share of the co l/or 18 are eligi	s Plan as ost of enro ble family	shown in Iten ollment as it is members as	ns 8 ar s now o	nd 9 ab or as it	ove and auth	orize deduc future. I al	so certify	that the na	mes of			<u> </u>		
20. EMPLOYEE OR AN	NUITANT'S SIGNA	TURE (see p	rivacy inf	formation on	revers	se of e	mployee co	ру)				1	- 1	SIGNED		
•				Т	ELEP	PHON	E NUMBEF	₹()			IV	10.	Day	Υ€	ear
▶ PLEASE REFI					CED	URE	MANU	AL FOR	1		ON O	FITE	MS	22-27		1
22. DEDUCTION 23 PLAN CODE	action 2. \square	New Cancel Change	24. PAY Month	PERIOD Year	25. P	PARTY	CODE		1	MPLOYEE DESIGNATI	ON	27. B	ARGA	AINING UNI	Τ	
				29. P	PAYRC	LL OFFICE	CODE	30. A	GENCY CO	DDE	31. UI	NIT C	ODE			
32. I hereby certify under penalty of perjury as follows: SIGNATURE OF HE			HEAL	LTH B	ENEFITS O	FFICER		ate receive								
	gency, and that paym y Sections 22870-229 hereby approved. Fina enrollment action sp	ent by the 05 of the al determina- ecified will	•						Mo.	Day	Year	34. PI	HONE	NUMBER		
Employees' Retiremer Public Employees' Me	tion of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act. MULTE LIP DINK A					of	BLUE - Emplo	Forms								

PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the California 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. Portions of this information may be transferred to another governmental 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, PERS, P.O. Box 942714, Sacramento, CA 94229-2714.

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. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and state benefits. Furthermore, the Office of Employer and Member Health Services requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits. Specifically, the California Public Employees' Retirement System uses Social Security 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 Public Employees' Retirement System and other state agencies.
- 5. Coordination of benefits among carriers.

BINDING ARBITRATION

Enrollment in certain plans constitutes an agreement to have any issue of medical malpractice decided by neutral arbitration and waiver of any right to a jury or court trial. Refer to the health plan Evidence of Coverage booklet to determine if this provision is applicable to your plan.



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:		
Social Security Number: (First)	(Last)	
What is the date you assumed the primary custodial parental role f	or 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	on 599.500(o)? Yes □	No □
If yes, what is the number of children enrolled under CCR section 599	9.500(o)?	
Note: A new Affidavit of Parent Child-Relationship form must be subm	nitted for each child.	
Eligibility		
I hereby certify I have assumed a parent-child relationship with the child not by the following:	amed above, as evidenced	Internal Use Only (HBO Initials)
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	
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								
or Employer Use:								
hereby certify under penalty of perjury as	s follows:							
hat I am a duly appointed, qualified, and	acting officer of the below named a	gency.						
I hereby certify I have reviewed the absubmitting this affidavit.	pove application and verified the ider	ntity of the employee						
Based on the information provided and this child according to CCR section 59	•	approving the enrollment of						
Recommend not approving the enrollr	ment of this child.							
lealth Benefits Officer Signature	Agency Name	 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

Office of Employer and Member Health Services P.O. Box 942714



Sacramento, CA 94229-2714 (888) CalPERS (225-7377) TDD - (916) 795-3240 FAX (916) 795-1277

MEMBER QUESTIONNAIRE for the CaIPERS DISABLED DEPENDENT BENEFIT

MEMB				ORMS WILL BE RETURNED CAUSING A DELAY IN BENEFITS.		
			DRMATION:	DEPENDENT INFORMATION:		
Name Social Addre Teleph	Security	Number ((SSN):	Name:Social Security Number (SSN):		
recerti disable	fication in ed if the p	the health erson is in	n plan under the disabled dependence plan under the disable of self-support (i.e., incap	ne dependent who is seeking initial or continued enrollment or ent benefit. For purposes of this benefit, a person is considered pable of any substantial gainful activity) as a result of a physical appleted form to the above address.		
			MEMBER Q	UESTIONNAIRE		
			Marital Status			
1.	Yes	No	If yes, do not complete the rem	is he or she ever been married? lainder of this form. to continue enrollment in the CalPERS Health Benefit Program.		
			Health Insurance and Heal	Ith Care		
2.			Is the dependent entitled to:			
	Yes	No	Medi-Cal? (If yes, attach a c	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 ca			
	Yes	No	Medicare Part B (medical care)? (If yes, attach a copy of the dependent's Medicare care			
	Yes	No	Other insurance? (If yes, specify the plan name and type of coverage.)			
3.	Yes	No	the past year?	-Home Supportive Services or in-home skilled nursing care in		
			Income and Support			
4.	Yes	No	,	dependent upon you for his or her support? dependent's monthly living expenses that you provide including g, medical, etc.)		
5.			Is the dependent entitled to rec	eive:		
	Yes	No	Social Security Disability Ins	urance (SSDI)?		
	Yes	No	Supplemental Security Incom	ne (SSI)?		
6.	Yes	No		attend school? the school(s) and course(s) of study.)		
		Т	Employment History			
7.	Yes	No	· —	d (including work through a sheltered workshop)?		
				employment and employer name(s) and address(es).)		
8.	Yes	No	Is the dependent working now?			
9.	Yes	No		is yes, attach proof of the dependent's earnings for the current ember) and the two previous years.		
	by certify	TIFICATI that, to		above information is complete and correct.		

I nereby certify that, to the best of h	ny knowledge, the above informa	ition is complete and correc
Member Name	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



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.

		L BE RETURNED CAUSING DELAT IN BENEFITS.
MEMBE	R PART A: THE MEMBER IS TO	
COMPL	ETE THE INFORMATION IN PART A:	
	MEMBER INFORMATION	DEPENDENT INFORMATION
NAME:		NAME:
	SECURITY NUMBER (SSN)	SSN
ADDRES	SS:	ADDRESS:
TELEPH	SS:ONE (_)	DATE OF BIRTH:
		
	DEPENDENT AUTHORIZATION: The dependent, mation requested in PART B prior to giving the form	
I hereby	authorize my attending physician	to furnish and disclose all
		edge and to allow inspection, and provide copies, of any
		r her control. This authorization shall be valid for a period of
		f this claim, whichever is later. I agree that a photocopy of
		d that if I do not sign this authorization, or if I revoke or modify
		isabled dependent and that my request may be denied. I
also unde	erstand that CalPERS will keep confidential the infor	mation which is provided pursuant to this authorization, and
that it wil	I be used solely to determine and act upon my reque	st for this benefit.
Signature	e of Dependent OR	Date Signed
-	·	•
Person a	uthorized to act on his/her behalf	Relationship to the dependent
PHYSICI	AN PART C: The physician is to complete all requ	ested information in PARTS C and D. All responses must be
health ins	ctor: ent requests you to complete this Medical Report for	m. It will assist CalPERS in processing his or her claim for rent's or guardian's health plan. By providing the medical
IIIOIIIIati		
	Medica	I Report
1.	I attended the patient for the current disabling med	ical problem or condition from to;
	At intervals of I la	st examined the patient on
2.	Medical History (related to disability): Date of Disa	bility 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 S	Symptoms: (see page 2, Items 6 and 7 for additional findings)
II .		
1	1	
5.	Current Treatment(s) and /or Medication(s) (rende	red to the patient for this disability):
5.	Current Treatment(s) and /or Medication(s) (rende	red to the patient for this disability):
5.	Current Treatment(s) and /or Medication(s) (rende	red to the patient for this disability):
5.	Current Treatment(s) and /or Medication(s) (rende	red to the patient for this disability):
5.	_	,
5.	_	red to the patient for this disability): ent(s) and/or medications for this disability. (Check if

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

SSN:	
Medical Report 6 Functional Assessment of Activities of Daily Living (ADLS): Indicate the patient's degree of physical or me	
Medical Report 6 Functional Assessment of Activities of Daily Living (ADLS): Indicate the patient's degree of physical or me	
6 Functional Assessment of Activities of Daily Living (ADLS): Indicate the patient's degree of physical or me	
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 Self-Care Skills Sensory Skills Cognitive Skills	ntal
sittingbathingseeingmemorystandingtoiletingspeechplanning/follow throughliftingdressingtouchthinking/processing informationbending	on
7. Psychological / Psychiatric Assessment: List the specific psychological / psychiatric symptoms or behavior any, that affect the patient's ADLs and limit his or her capacity to be self-supporting:	s, if
PART D: Medical Certification of Disability and Incapacity of Self Support: For purposes of this benefit, a Calf member can retain his or her eligibility for health benefits as a family member if he or she is unmarried and incapable self-support (i.e., not capable of engaging in any substantial gainful activity) due to physical or mental disability whice 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 of the patient currently have a physically or mentally disabling injury, illness of the patient currently have a physically or mentally disabling injury.	e of ch
condition? NO, the patient does NOT have a physically of mentally disabling injury, illness or condition. YES (Please answer Question 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 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 pat not and will not be capable of self support within the foreseeable future (e.g., more than 5 years).	ent is
I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability or her capability of self support, and that I am a	and his
(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:	
THINT, THE DISTANCE THIS COUNTY OF A STOWN ON EIGENSE AND THE ADDRESS, TELEFHONE AND THA NOMBERS.	
PHYSICIAN'S NAME AS SHOWN ON LICENSE ORIGINAL SIGNATURE OF ATTENDING PHYSICIAN'S NAME AS SHOWN ON LICENSE	SICIAN
LOCAL ADDRESS STATE LICENSE NUMBER	
CITY STATE () TELEPHONE NUMBER	
DATE ()FAX NUMBER	
PART E: CalPERS USE ONLY:	
Claim approved for appallment through	
Claim approved for enrollment through	

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



Health Care and Dependent Care Flexible Spending Accounts Enrollment Form

Employer Use Only
Re-enrollment New Change
Effective Date
1st Deduction Date
Payroll Mode W B S M Q
Division Code

Date Rev. 1/2012

I. Personal Information (Please pri	int clearly and provi	de complete and acc	urate infori	mation.)		ode		
Your Employer:								
Member #)						
(This may be your SSN or employer as	ssigned number)		(Last)		(F	irst)		(MI)
Address	City	<i>y</i>		State	_ Zip			
☐ Check if this address is new within last year.	Date of Birth	//		Hire Date _		_/	_/	
II. Election Information (Please che	eck the appropriate	box to indicate if you	wish to er	nroll, or do not wish	to enr	oll, and sig	n below.))
 Yes, I wish to participate in the flexible spend below, and continuing until this election is a automatically reduced from my compensation I have been offered the opportunity to enroll benefit coverage contributions are automatical 	mended or terminate on a pre-tax basis. in the flexible spendi	ed or until the Plan Ying account plan and	ear ends. do not wish	Employer-sponsored	l benef	it coverage	contribut	ions are
BENEFIT CHOICES		PER PAY PERIOD AMOUNT)	NUMBER OF PAY PERIODS		PLAN Y AMOUN		
lealthcare Flexible Spending Account								
The minimum and/or maximum contribution amou determined by your employer.	ints are	\$	_ X		=	\$		-•
The minimum contribution amount is determined by however the maximum contribution amount of \$5,0 IRS. If married, and your spouse is disabled, a full-time less than you, lower limits may apply. Please referenced by the properties of the second se	000 is set by the student or earns	\$	_ x		=	\$		_•
I understand that:								
 This election can only be changed or revol participate. The new election must be consist by my employer. This election will be automatically changed sponsored benefit contributions increase or consist that the consist individuals filing separately will get a lower expensed and any amounts remaining in my reimbursement and any amounts form must be completed opportunity to participate in the Benefit Choice. Social Security and Medicare taxes are not be a the amount of salary reductions may not be a lift my employment terminates, only medical ending in the lift of the conference of the payFlex Debit Card, I agree to use the cardholder statement I receive with the conference of the payFlex Debit Card, I agree to use the cardholder statement I receive with the conference of the payFlex Debit Card, I agree to use the cardholder statement I receive with the conference of the payFlex Debit Card, I agree to use the cardholder statement I receive with the conference of the payFlex Debit Card, I agree to use the cardholder statement I receive with the conference of the payFlex Debit Card, I agree to use the cardholder statement I receive with the conference of the payFlex Debit Card, I agree to use the cardholder statement I receive with the conference of the payFlex Debit Card, I agree to use the cardholder statement I receive with the conference of the payFlex Debit Card, I agree to use the cardholder statement I receive with the conference of the payFlex Debit Card, I agree to use the cardholder statement I receive with the cardhol	or cancelled, if necessive cancelled, if necessive care Reimburseme calcusion (\$2,500 per cancelled) at accounts at the encecount cannot be trained each Plan Year. If these outlined above, being withheld on the claimed on my or my expenses incurred thresement are subject to use the card for eligible and I understand	essary, to comply with the Account for married calendar year). IRS For the Plan Year will the Insferred and used for each of the Instead of the Married and used for each of the Instead o	olied for with provisions in provisions in individuals orm 2441 m per forfeited. Expenses in individuals expenses in individuals expenses in individuals expenses in individuals expenses and returns. Expenses and expenses and interest in all ite inactivation	nin 30 days of the character if I do not comply with a soft and a soft a	enue C s \$5,00 ersona uring C be con I agree ments.	code or if real of the common	equired er dar year. c return. ment, I for reimburse document ead and a r upon teri	approval mployer- Married refeit the ment. ration as dhere to mination
III. Pre-Authorization for Direct	Deposit (If you	u are already enrolled	d in direct o	deposit or do not wi	sh to i	anore this	section \	
I authorize PayFlex Systems USA, Ir This agreement is to remain in full effect A "VOIDED" CHECK MUST ACCOMPA	nc. to initiate a cre until written notif	edit and/or debit e ication is supplied	ntry to my by me to	account for my F	PayFle	ex reimbu	rsemen	ts.

≥ Employee Signature _____



<u>Payroll</u>

Tax Shelter Annuities - 403(b) and Deferred Compensation Plans - 457 (b)

- * PREFERRED VENDORS LIST for 403(b), Roth 403 (b) and 457 (b)
- * What is a 403b?
- * ROTH 403B
- * Roth 403 b Q & A
- * Hold Harmless
- * Information Sharing Agreement
- * 403b Hardship Process1
- * "Hardship Form1"
- * Vendor Loan Supplement
- * What is a 457?

At its meeting of September 13, 2004 the Board of Trustees approved a deferre compensation plan under Section 457 of the Internal Revenue Code. The new 457 plan will complement the current 403(b) plan.

The District has chosen VALIC and Tax Deferred Services (TDS) to provide 457 retirement plan products to the employees.

The 457 Program would allow employees to defer \$17,000.00 for the calendar year 2012 in addition to the \$17.000.00 permitted under the 403(b) plan for a combined maximum of \$34,000.00 for year 2012 (with amounts scheduled to increase annually). In addition, there are age-based and retirement catch-up contributions, if qualified. For detailed information on 457 plan, click What is a 457?

For additional details, you may contact Rachelle Licon at extension 6115 or liconrachelle@fhda.edu.

- * Other Links, Letters and Historical Events:
- * http://www.403bcompare.com/ The 403bCompare Web site is a bank of free objective information about 403(b) vendors and the products they offer.

Forms

Plans - 403(b) and 457

Direct Deposit

Pay Schedules

Payroll Issues

Staff Contacts

On-Line Time Report



Search



<u>Payroll</u>

PREFERRED VENDORS LIST

The IRS has revised regulations for 403(B) plans. The new regulations will take effect on January 01, 2009. The following is a list of Foothill - De Anza Community College District approved 403(B) vendors. After December 31, 2008, only the list of vendors below is authorized to accept your 403(B) contributions. If you need more information, please send an e-mail to: liconrachelle@fhda.edu

* 403 (b) PREFERRED VENDOR LIST

- 1./ AMERICAN FUNDS SVCS. (Plan #96594) Tel: (800) 421-0180 http://www.americanfunds.com
- 2./ FIDELITY INVESTMENTS (Plan #51275) Tel: (800) 835-5097 http://www.fidelity.com
- 3./ FIRST INVESTORS CORP Tel: (800) 995-2885 http://www.firstinvestors.com
- 4./ METROPOLITAN LIFE INSURANCE CO. Tel: (800) 560-5001 http://www.metlife.com
- 5./ MIDLAND NATIONAL LIFE INS Tel: (877) 586-0240 http://www.mnlife.com/
- 6./ ING/RELIASTAR LIFE INS. CO Tel: (877) 882-5050 http://www.ing.com
- 7./ **T-ROWE PRICE TRUST** Tel: (800)492-7670 http://individual.troweprice.com/public/Retail
- 8./ TIAA-CREF (Group #B472) Tel: (888) 842-7782 http://www.tiaa-cref.org
- 9./ VALIC Tel: (800) 448-2542 http://www.valic.com
- 10./ VANGUARD FIDUCIARY TRUST CO (Group #10100722) Tel: (800) 662-2003 http://www.vanguard.com

* 403(b) Preferred Vendors also offering Roth 403(b) plan

- 1./ FIRST INVESTORS CORPORATION Tel: (408) 452-4200
- 3./ ING/RELIASTAR LIFE INS. CO Tel: (877) 882-5050 http://www.ing.com
- 4./ VALIC Tel: (800) 448-2542 http://www.valic.com

* For 457(b) and Roth 457

- 1./ EBSG Employee Benefits Services Group 2542 S. Bascom Ave, Suite 100 Campbell, CA 95008 Telephone: (408) 978-1000 x 135 Cell phone: (408) 396-6988 Fax: (408) 228-8950 Email: dwang@ebenefitsservices.net Email: doris_wang@yahoo.com
- 2./ **VALIC**

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About Us Business Human Resources Facilities Purchasing Foundation Technology Research



Search

IMPORTANT! You should review this agreement with the agent representing each issuing company from which an annuity contract must be established <u>before</u> you file the agreement with the Office of Payroll Services.

Amendment of Employment Contract

It is agreed by the Foothill-DeAnza Communi			
them for the 2020 school year be ame	nded as follows:	oyee, mat me Employi	nent contract between
Beginning with the salary warrant payabl \$ per month under pre-tax	e on, 20 the Dist basis 403(b) and \$ p	rict shall reduce the sala er month under after-ta	ary due the employee by a basis Roth 403(b).
• The District will apply the monthly reduc contract (or contracts), and the monthly p			on-transferable annuity
Tax Sł	nelter Annuity Program (Pro	e-tax basis)	
Name of Issuing Company	Remittance Address	Account Number	Monthly Amount
			\$
			\$
	Total Pre-tax Reduction:		\$
Rot	th 403(b) Program (After-ta	x basis)	
Name of Issuing Company	Remittance Address	Account Number	Monthly Amount
			\$
			\$
	Total After-tax Reduction:		\$
Total Monthly Reduction: \$		mated Reduction: \$ basis+ After-tax basis)	
 The District may use the services of a remitting ager annuity purchase under this salary reduction agreem contract (or contracts) under this agreement to each for which the corresponding salary reduction was m The employee, for him/herself, spouse, heirs, admin form than payments from the issuing company the a The purpose of this agreement is to enable the employee regarding assumes full responsibility for conforming all computations assumes full responsibility for conforming all computations resulting from any such computations, his oprovided by said company or companies. This amendment shall automatically apply to the employee it is amended or terminated by written notice termination is to take effect. 	ent. The District's remitting agency shall tra- issuing company in the manner specified abo- ade. istrators, executors, and representatives herel- mounts to be applied toward annuity premiur oyee to participate in an annuity program, as ling provisions of the California Revenue and g the advisability or tax consequences of the utations in connection with the salary reducti- lations thereunder. Finally, the employee rel er her selection of an issuing company or com apployment contract entered into between the I to the District, received by the Office of Pay ALARY REDUCTION AGREEMENTS FII	asmit the amounts to be applied to the no later than 10 working do by releases all rights, present and payments under this agreement described in Section 403, Subdia Taxation Code. The employed purchase described herein. From the requirements of the eases the District, its officers, panies, or from the solvency of the color of the solvency of the s	ed to the purchase of an annuity ays after the end of the pay period and future, to receive in any other tent. division (b) of the Internal ree acknowledges that the District Furthermore, the employee Internal Revenue Code, the and employees, from any liability of, operation of, or benefits each succeeding school year perfore the amendment or
ANNUITY PROGRAM. ON AND AFTER THE EFFECT WILL BE THE REDUCTION SPECIFIED IN THIS AGE Employee's Signature		UNLY SALARY REDUCTI	UN THAT WILL BE MADE
	By		- Diampic
Social Security Number	FOOTHILL-DE ANZA CO	MMUNITY COLLEGI	E DISTRICT
Agent's Signature	Agent's Name	Agent's Pho	one Number



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

GENERAL EMPLOYEE INFORMATION

Social Security #	Name
Social Security "	Name:(Name as it appears on Social Security Card)
Preferred Name: (First Name ONLY: name desired to be a	Telephone:
(<u>First Name ONLY</u> : name desired to be a	ddressed as by colleagues)
Address	City/State/Zip:
Person to contact in case of emerge	ncy:
Name:	Phone:
Address:	City/State/Zip:
Relationship to employee:	
Section B – Oath of Office (Requ	ired under Government Code Section 3102)
enemies, foreign or domestic; that	t I will bear true faith and allegiance to the Constitution of the Unite
enemies, foreign or domestic; that States and the Constitution of the reservation or purpose of evasion; about to enter.	t I will bear true faith and allegiance to the Constitution of the Unite State of California; that I take this obligation freely, without any menta and that I will well and faithfully discharge the duties upon which I ar
enemies, foreign or domestic; that States and the Constitution of the reservation or purpose of evasion; about to enter. Signature:	t I will bear true faith and allegiance to the Constitution of the Unite State of California; that I take this obligation freely, without any menta and that I will well and faithfully discharge the duties upon which I ar Date:
enemies, foreign or domestic; that States and the Constitution of the reservation or purpose of evasion; about to enter. Signature:	t I will bear true faith and allegiance to the Constitution of the Unite State of California; that I take this obligation freely, without any menta and that I will well and faithfully discharge the duties upon which I ar Date:
enemies, foreign or domestic; that States and the Constitution of the reservation or purpose of evasion; about to enter. Signature:	t I will bear true faith and allegiance to the Constitution of the Unite State of California; that I take this obligation freely, without any menta and that I will well and faithfully discharge the duties upon which I ar Date: Lion to Receive Warrants
enemies, foreign or domestic; that States and the Constitution of the reservation or purpose of evasion; about to enter. Signature: Section C - Affidavit of Designary The text of Government Code Section C - Affidavit of Designary The text of Government Code Section C - Affidavit of Designary The text of Government Code Section C - Affidavit of Designary and Section C - Affidavit of Designary The text of Government Code Section C - Affidavit of Designary and Section C - Affidavit of Designary The text of Government Code Section C - Affidavit of Designary and Section C - Affidavit of Designa	t I will bear true faith and allegiance to the Constitution of the Unite State of California; that I take this obligation freely, without any menta and that I will well and faithfully discharge the duties upon which I ar
enemies, foreign or domestic; that States and the Constitution of the reservation or purpose of evasion; about to enter. Signature: Section C - Affidavit of Designar The text of Government Code Section C - Affidavit of Designar The text of Government C - Affidavit of Designar The text of Government C - Affidavit of Designar The text of Government C - Affidavit of Designar The text of Government C - Affidavit of Designar The text of Government C - Affidavit of Designar The text of Government C - Affidavit of Designar The text of Government C - Affidavit of Designar The text of Gov	tion to Receive Warrants tion 53245 is as follows: ereafter employed by a county, city, municipal corporation, district, of the with his/her appointing power a designation of a person who vision of law, shall, on the death of the employee, be entitled to receive would have been payable to the decedent had he/she survived. The signation from time to time. A person so designated shall claim such to the claimant. A person who receives a warrant or check pursuant to
enemies, foreign or domestic; that States and the Constitution of the reservation or purpose of evasion; about to enter. Signature: Section C - Affidavit of Designation The text of Government Code Section 1 Salar S	t I will bear true faith and allegiance to the Constitution of the Unite State of California; that I take this obligation freely, without any menta and that I will well and faithfully discharge the duties upon which I ar Date: Date:

Section D – Equal Opportunity Survey

The Foothill-De Anza Community College District is committed to diversity and actively recruits women, persons with disabilities, members of underrepresented ethnic groups, and veterans of the Vietnam era. We are required to provide demographic information to state and federal agencies to demonstrate our commitment. Therefore, please provide the information requested below so that we may have accurate data for reporting our Diversity goals. Completion of this form is voluntary. Failure to complete this form will not impact your employment and the information you provide is confidential.

Gender:MaleFemale	
Ethnic Identification (Check only one)	
Are you Hispanic or Latino?	
NOYES (1)	
If yes, please select all that apply:	
Mexican, Mexican American or Chica Central American (3) South American (4) Other Hispanic (5)	one or more of the following to describe your <u>racial background:</u>
-	
Asian Indian (6)	Asian other (14)
_Asian Chinese (7)	Black or African American (15)
Asian Japanese (8)	American Indian/Alaskan Native (16)
Asian Korean (9)	Pacific Islander Guamanian (17)
Asian Laotian (10)	Pacific Islander Hawaiian (18)
Asian Cambodian (11)	Pacific Islander Samoan (19)
Asian Vietnamese (12)	Pacific Islander Other (20)
Filipino (13)	White (21)
more major life activities; or (2) a record of such	nas (1) a physical or mental impairment that substantially limits one or impairment; or (3) is regarded as having such impairment.)
Yes Specify:	
No	
Are you a Vietnam Era Veteran? Service Date Yes No	es must be between August 5, 1964 and May 7, 1975.
I choose not to complete this portion	of the form.
Signature:	Date:

BENEFICIARY DESIGNATION



honoficians decisoration(s) if any for my	Change of a	ılı prior beneticiary design:	ation(s) (ch	eck only one box), I hereby revoke any previous
group or employer and direct that the insu	roup term life insura rance proceeds pay	ance and/or accidental de- able under the policy be	ath and dis	memberment (AD&D) insurance issued to this icated below.
Employee Name				Social Security Number
Employee Address				Telephone Number
Policyholder/Employer				Policy/Employer Number
primary and contingent beneficiary. Where relationship if the beneficiary is not relationered beneficiary is named without a percentage of common beneficiary designations. If y	ation be clear so the n naming your bene ed either by blood o e indicated, the pro- rou need assistance	at there will be no question officiary(ies) please indicate or marriage, insert the work ceeds will be divided equal, contact your Company	e their full i ds, "Not Re ally. On the representa	
PRIMARY BENEFICIARY(IES)	Basic	Supplemental		Basic and Supplemental
Name:				Date of Birth
Address: Social Security Number:	Relation			Benefit Percent:
Name:				Date of Birth
Address:				
Social Security Number:	Relation	ship:		Benefit Percent:
CONTINGENT BENEFICIARY(IES)	Basic	Supplemental		ssic and Supplemental
Name:				Date of Birth
Address:				
Social Security Number:	Relation	ship:		Benefit Percent:
				D . 4 D . 4
Name:				Date of Birth
				Date of Birth
				Benefit Percent:
Address: Social Security Number: Spousal Consent For Community P Louisiana, Nevada, New Mexico, Texallows your spouse to waive his or hidoes not apply to ERISA plans.	roperty States On tas, Washington, er rights to any consurance under the munity property	ship: nly: If you live in a con or Wisconsin - you ma ommunity property inte ed above, I hereby cor he above policy and w	nmunity properties of the complete comp	Benefit Percent: roperty state- Arizona, California, Idaho, te the Spousal Consent section, which e benefit. Disclaimer: spousal consent by spouse designating the person(s) listed rights I may have to the proceeds of
Address: Social Security Number: Spousal Consent For Community P Louisiana, Nevada, New Mexico, Texallows your spouse to waive his or hidoes not apply to ERISA plans. This will certify that, as spouse of the above as beneficiaries) of group life is such insurance under applicable com	Relation roperty States Or tas, Washington, er rights to any c Employee name nsurance under to munity property s plan.	ship:	nmunity properties of the control of	Benefit Percent: roperty state- Arizona, California, Idaho, te the Spousal Consent section, which e benefit. Disclaimer: spousal consent by spouse designating the person(s) listed rights I may have to the proceeds of sent and waiver supersede any prior
Spousal Consent For Community P Louisiana, Nevada, New Mexico, Texallows your spouse to waive his or hidoes not apply to ERISA plans. This will certify that, as spouse of the above as beneficiaries) of group life is such insurance under applicable comspousal consent or waiver under this	Relation roperty States On tas, Washington, er rights to any co e Employee name insurance under the inmunity property is plan.	ship: nly: If you live in a con or Wisconsin - you ma ommunity property into ed above, I hereby cor he above policy and w laws. I understand tha	nmunity property complete and the major and the major and the conference of the conf	Benefit Percent: Toperty state- Arizona, California, Idaho, te the Spousal Consent section, which e benefit. Disclaimer: spousal consent by spouse designating the person(s) listed rights I may have to the proceeds of sent and waiver supersede any prior

Form W-4 (2013)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

0	o carriere, manipie je		may owe additional tax. If yo	ou have pension or annuity		
		Persona	l Allowances Works	heet (Keep for your records.)		
A	Enter "1" for yo	urself if no one else can o	claim you as a dependent	t		A
	(You are single and have	e only one job; or)	
В	Enter "1" if:	 You are married, have 	only one job, and your sp	pouse does not work; or	} .	В
	l	 Your wages from a sec 	ond job or your spouse's v	wages (or the total of both) are \$1,50	00 or less. ^J	
С				ou are married and have either a w	orking spouse o	or more
	than one job. (E	intering "-0-" may help yo	u avoid having too little ta	ax withheld.)		· · C
D	Enter number of	f dependents (other than	your spouse or yourself)	you will claim on your tax return.		D
E	Enter "1" if you	will file as head of house	hold on your tax return (s	see conditions under Head of hou s	sehold above)	E
F				expenses for which you plan to cla		F
				d and Dependent Care Expenses,		
G				72, Child Tax Credit, for more info		
), enter "2" for each eligible child; t	hen less "1" if y	ou
		x eligible children or less	· · · · · · · · · · · · · · · · · · ·			
	•	· ·		\$119,000 if married), enter "1" for each	ŭ	
Н	Add lines A throu	•	•	from the number of exemptions you cl	•	· —
	For accuracy,	 If you plan to itemize and Adjustments W 		income and want to reduce your with	hholding, see the	Deductions
	complete all			or are married and you and your	spouse both wo	ork and the combine
	worksheets	earnings from all jobs	exceed \$40,000 (\$10,000 i	f married), see the Two-Earners/M	ultiple Jobs Wo	rksheet on page 2 t
	that apply.	avoid having too little ta			Las Park Earl Earl	an NAV A landana
		• It neitner of the above	e situations applies, stop n	nere and enter the number from line I	on line 5 of For	n vv-4 below.
		Separate here and	give Form W-4 to your en	nployer. Keep the top part for your	records	
	W A	Fmplove	e's Withholding	g Allowance Certifica	te l	OMB No. 1545-0074
Form	VV -4		_		i	$\bigcirc \bigcirc $
	ment of the Treasury I Revenue Service			er of allowances or exemption from wit be required to send a copy of this form t		<u> </u>
1		and middle initial	Last name		2 Your social	security number
	Home address (r	number and street or rural route)	3 Single Married Mar	ried, but withhold at	higher Single rate.
				Note. If married, but legally separated, or spo		
	City or town, sta	te, and ZIP code		4 If your last name differs from that	shown on your so	ial security card,
				check here. You must call 1-800-	772-1213 for a rep	lacement card. ▶
5	Total number	of allowances you are cla	iming (from line H above	or from the applicable worksheet	on page 2)	5
6						
7	I claim exemp	otion from withholding for	2013, and I certify that I r	meet both of the following conditio	ns for exemption	า.
	• Last year I h	nad a right to a refund of a	II federal income tax with	held because I had no tax liability,	and	
	• This year I e	expect a refund of all fede	ral income tax withheld b	ecause I expect to have no tax liab	oility.	
		<u> </u>	<u>'</u>		7	
Unde	er penalties of perj	jury, I declare that I have ex	amined this certificate and	, to the best of my knowledge and be	elief, it is true, co	rrect, and complete.
Empl	loyee's signature)				
(This	form is not valid ι	unless you sign it.) ▶			Date ►	
8	Employer's name	e and address (Employer: Com	plete lines 8 and 10 only if sen	ding to the IRS.) 9 Office code (optional)	10 Employer ide	entification number (EIN)

Form W-4 (2013) Page **2**

			Deduct	ions and A	diust	ments Works	heet			
Note	Use this work	sheet <i>only</i> if						to income		
1	te. Use this worksheet only if you plan to itemize deductions or claim certain credits or adjustments to income. Enter an estimate of your 2013 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1949) of your income, and miscellaneous deductions. For 2013, you may have to reduce your itemized deductions if your income is over \$300,000 and you are married filing jointly or are a qualifying widow(er); \$275,000 if you are head of household; \$250,000 if you are single and not head of household or a qualifying widow(er); or \$150,000 if you are married filing separately. See Pub. 505 for details									
		•		•		y separately. See Fut 1	o. 303 for details		1 \$	
2	Enter: { \$8	3,950 if head	ied filing jointly or qua of household or married filing sepa		v(er)	}			2 \$	
_			• .	•					o ¢	
3			. If zero or less, enter						3 <u>\$</u> 4 \$	
4		•	013 adjustments to inc	•			•	,	4 \$	
5	Withholding A	Allowances fo	nter the total. (Includ r 2013 Form W-4 wor	ksheet in Pul	o. 505	.)			5 \$	
6			2013 nonwage incom						6 \$	
7			. If zero or less, enter						7 \$	
8			7 by \$3,900 and ente						8	
9			Personal Allowance						9	
10			er the total here. If you							
			1 below. Otherwise,						10	
			rs/Multiple Jobs				or multiple j	obs on page	e 1.)	
Note.		,	the instructions unde	•	•	•				
1			page 1 (or from line 10 a	•			-	,	1	
2	you are marri	ed filing jointl	1 below that applies y and wages from the		ing job	are \$65,000 or I			2	
3	If line 1 is m	ore than or	equal to line 2, subti	ract line 2 fro	om line	e 1. Enter the re	sult here (if z	ero. enter	- —	
Ū			ne 5, page 1. Do not				•		3	
Note.			enter "-0-" on Form							
			olding amount necess		_	•	cg c			
4	_		2 of this worksheet	-	-		4			
5			1 of this worksheet				5			
6									6	
7			2 below that applies to						7 \$	
8			d enter the result here						8 \$	
9		•	of pay periods remaining				•		· ·	
-		-	is form on a date in Ja	-				-		
			W-4, line 6, page 1. Th						9 \$	
		Tab	le 1				Tal	ble 2		
	Married Filing		All Other	s		Married Filing J			All Other	'S
	s from LOWEST job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above		ges from HIGHEST g job are—	Enter on line 7 above	If wages from I		Enter on line 7 above
\$	0 - \$5,000	0	\$0 - \$8,000	0		\$0 - \$72,000	\$590		\$37,000	\$590
	11 - 13,000 11 - 24,000	1 2	8,001 - 16,000 16,001 - 25,000	1 2		2,001 - 130,000 0,001 - 200,000	980 1,090	37,001 - 80,001 -		980 1,090
24,00	1 - 26,000	3	25,001 - 30,000	3	200	0,001 - 345,000	1,290	175,001 - 3	385,000	1,290
26,00	1 - 30,000	4	30,001 - 40,000	4	34	5,001 - 385,000	1,370	385,001 and		1,540
	11 - 42,000 11 - 48,000	5 6	40,001 - 50,000 50,001 - 70,000	5 6	38	5,001 and over	1,540			
48,00	1 - 55,000	7	70,001 - 80,000	7						
	11 - 65,000 11 - 75,000	8 9	80,001 - 95,000 95,001 - 120,000	8 9						
	11 - 75,000	10	120,001 - 120,000 120,001 and over	10						
85,00	1 - 97,000	11								
	11 - 110,000 11 - 120,000	12 13								
	1 - 135,000	14								

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

135,001 and over

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



This form can be used to manually compute your withholding allowances, or you can electronically compute them at www.taxes.ca.gov/de4.pdf

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Type or Print Your Full Name	Your Social Security Number
Home Address (Number and Street or Rural Route)	Filing Status Withholding Allowances SINGLE or MARRIED (with two or more incomes)
City, State, and ZIP Code	☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD
Number of allowances for Regular Withholding Allowances, Worksheet A	
Number of allowances from the Estimated Deductions, Worksheet B Total Number of Allowances (A + B) when using the California Withholding Schedules for 2013 OR	
Additional amount of state income tax to be withheld each pay period (if en OR	mployer agrees), Worksheet C
3. I certify under penalty of perjury that I am not subject to California withholdi the Service Member Civil Relief Act, as amended by the Military Spouses F	
Under the penalties of perjury, I certify that the number of withhold the number to which I am entitled or, if claiming exemption from w	
Signature	Date
Employer's Name and Address	California Employer Account Number
cut her	ere
Give the top portion of this page to your employer and keep the remainder for	r your records.

YOUR CALIFORNIA PERSONAL INCOME TAX MAY BE UNDERWITHHELD IF YOU DO NOT FILE THIS DE 4 FORM.

IF YOU RELY ON THE FEDERAL FORM W-4 FOR YOUR CALIFORNIA WITHHOLDING ALLOWANCES, YOUR CALIFORNIA STATE PERSONAL INCOME TAX MAY BE UNDERWITHHELD AND YOU MAY OWE MONEY AT THE END OF THE YEAR.

PURPOSE: This certificate, DE 4, is for <u>California</u> Personal Income Tax (PIT) withholding purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

You should complete this form if either:

- (1) You claim a different marital status, number of regular allowances, or different additional dollar amount to be withheld for California PIT withholding than you claim for federal income tax withholding or,
- (2) You claim additional allowances for estimated deductions.

THIS FORM WILL NOT CHANGE YOUR FEDERAL WITHHOLDING ALLOWANCES.

The federal Form W-4 is applicable for California withholding purposes if you wish to claim the same marital status, number of regular allowances, and/or the same additional dollar amount to be withheld for state and federal purposes. However, federal tax brackets and withholding methods do not reflect state PIT withholding tables. If you rely on the number of withholding

allowances you claim on your Form W-4 withholding allowance certificate for your state income tax withholding, you may be significantly underwithheld. This is particularly true if your household income is derived from more than one source.

CHECK YOUR WITHHOLDING: After your Form W-4 and/or DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form, and for federal withholding use the Internal Revenue Service (IRS) Publication 919 or federal withholding calculations.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4. You may claim exempt from withholding California income tax if you did not owe any federal income tax last year and you do not expect to owe any federal income tax this year. The exemption automatically expires on February 15 of the next year. If you continue to qualify for the exempt filing status, a new Form W-4 designating EXEMPT must be submitted before February 15. If you are not having federal income tax withheld this year but expect to have a tax liability next year, the law requires you to give your employer a new Form W-4 by December 1.

EXEMPTION FROM WITHOLDING (continued): Under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from California income tax on your wages if (i) your spouse is a member of the armed forces present in California in compliance with military orders; (ii) you are present in California solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under this act, check the box on Line 3. You may be required to provide proof of exemption upon request.

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL THE FRANCHISE TAX BOARD.

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES

800-852-5711 (voice) 800-822-6268 (TTY)

IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free) 9

916-845-6500

The California Employer's Guide (DE 44) provides the income tax withholding tables. This publication may be found on the Employment Development Department (EDD) website at www.edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm. To assist you in calculating your tax liability, please visit the Franchise Tax Board website at: www.ftb.ca.gov/individuals/index.shtml.

NOTIFICATION: Your employer is required to send a copy of your DE 4 to the Franchise Tax Board (FTB) if it meets either of the following two conditions:

- You claim more than 10 withholding allowances.
- You claim exemption from state or federal income tax withholding and your employer expects your usual weekly wages to exceed \$200 per week.

IF THE IRS INSTRUCTS YOUR EMPLOYER TO WITHHOLD FEDERAL INCOME TAX BASED ON A CERTAIN WITHHOLDING STATUS, YOUR EMPLOYER IS REQUIRED TO USE THE SAME WITHHOLDING STATUS FOR STATE INCOME TAX WITHHOLDING IF YOUR WITHHOLDING ALLOWANCES FOR STATE PURPOSES MEET THE REQUIREMENTS LISTED UNDER "NOTIFICATION." IF YOU FEEL THAT THE FEDERAL DETERMINATION IS NOT CORRECT FOR STATE WITHHOLDING PURPOSES, YOU MAY REQUEST A REVIEW.

To do so, write to:

W-4 Unit Franchise Tax Board MS F180 P.O. Box 2952 Sacramento, CA 95812-2952

Fax: 916-843-1094

Your letter should contain the basis of your request for review. You will have the burden of showing the federal determination incorrect for state withholding purposes. The FTB will limit its review to that issue. The FTB will notify both you and your employer of its findings. Your employer is then required to withhold state income tax as instructed by FTB. In the event FTB or IRS finds there is no reasonable basis for the number of withholding exemptions that you claimed on your Form W-4/DE 4, you may be subject to a penalty.

PENALTY: You may be fined \$500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided for by Section 19176 of the California Revenue and Taxation Code.

INSTRUCTIONS — 1 — ALLOWANCES*

When determining your withholding allowances, you must consider your personal situation:

- Do you claim allowances for dependents or blindness?
- Are you going to itemize your deductions?
- Do you have more than one income coming into the household?

TWO-EARNER/TWO-JOBS: When earnings are derived from more than one source, underwithholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with <u>one</u> employer. Do <u>not</u> claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 or Form W-4 filed for the highest paying job and zero allowances are claimed for the others.

MARRIED BUT NOT LIVING WITH YOUR SPOUSE: You may check the "Head of Household" marital status box if you meet <u>all</u> of the following tests:

- (1) Your spouse will not live with you at any time during the year;
- (2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; <u>and</u>
- (3) You will file a separate return for the year.

HEAD OF HOUSEHOLD: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the <u>entire</u> year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

WORKSHEET A	REGULAR WITHHOLDING ALLOWANCES	
(A) Allowance for yourself — enter 1		
(B) Allowance for your spouse (if not separately cla	aimed by your spouse) — enter 1 (B)	
(C) Allowance for blindness — yourself — enter 1	(C)	
(D) Allowance for blindness — your spouse (if not	separately claimed by your spouse) — enter 1 (D)	
(E) Allowance(s) for dependent(s) — do not includ	e yourself or your spouse (E)	
(F) Total — add lines (A) through (E) above		

INSTRUCTIONS — 2 — ADDITIONAL WITHHOLDING ALLOWANCES

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim one or more additional withholding allowances. Use last year's FTB 540 form as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each \$1,000, or fraction of \$1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

wc	PRKSHEET B ESTIMATED DEDUCTIONS			
1.	Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB 540 form		1	
2.	Enter \$7,682 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or \$3,841 if single or married filing separately, dual income married, or married with multiple employers	_	2	
3.	Subtract line 2 from line 1, enter difference	=	3	
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+	4	· · · · · · · · · · · · · · · · · · ·
5.	Add line 4 to line 3, enter sum	=	5	
6.	Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	_	6	
7.	If line 5 is greater than line 6 (if less, see below); Subtract line 6 from line 5, enter difference	=	7	
8.	Divide the amount on line 7 by \$1,000, round any fraction to the nearest whole number Enter this number on line 1 of the DE 4. Complete Worksheet C, if needed.		8	
9.	If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)		9	
10.	Enter amount from line 5 (deductions)		10	
	Subtract line 10 from line 9, enter difference		11	

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California Personal Income Tax (PIT) withholding and PIT wages. This new law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of Section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 888-745-3886.

TAX WITHHOLDING AND ESTIMATED TAX

1.	Enter estimate of total wages for tax year 2013
2.	Enter estimate of nonwage income (line 6 of Worksheet B)
3.	Add line 1 and line 2. Enter sum
4.	Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest) 4.
5.	Enter adjustments to income (line 4 of Worksheet B)
6.	Add line 4 and line 5. Enter sum
7.	Subtract line 6 from line 3. Enter difference
8.	Figure your tax liability for the amount on line 7 by using the 2013 tax rate schedules below 8.
9.	Enter personal exemptions (line F of Worksheet A x \$114.40)
10.	Subtract line 9 from line 8. Enter difference
11.	Enter any tax credits. (See FTB Form 540)
12.	Subtract line 11 from line 10. Enter difference. This is your total tax liability 12.
13.	Calculate the tax withheld and estimated to be withheld during 2013. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2013. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2013 13.
14.	Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld
15.	Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4 15.

NOTE: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

THESE TABLES ARE FOR CALCULATING WORKSHEET C AND FOR 2013 ONLY

SINGLE OR MARRIED WITH DUAL EMPLOYERS					
IF THE TAXABLE INCOME IS COMPUTED TAX IS					
OVER	BUT NOT	OF AMOUNT		PLUS*	
	OVER	OVER			
\$0	\$7,455	1.100%	\$0	\$0.00	
\$7,455	\$17,676	2.200%	\$7,455	\$82.01	
\$17,676	\$27,897	4.400%	\$17,676	\$306.87	
\$27,897	\$38,726	6.600%	\$27,897	\$756.59	
\$38,726	\$48,942	8.800%	\$38,726	\$1,471.30	
\$48,942	\$250,000	10.230%	\$48,942	\$2,370.31	
\$250,000	\$300,000	11.330%	\$250,000	\$22,938.54	
\$300,000	\$500,000	12.430%	\$300,000	\$28,603.54	
\$500,000	\$1,000,000	13.530%	\$500,000	\$53,463.54	
\$1,000,000	and over	14.630%	\$1,000,000	\$121,113.54	

MARRIED FIL	ING JOINT OR QU	ALIFYING W	/IDOW(ER) TA	XPAYERS
IF THE TAXABL	E INCOME IS		COMPUTED TA	AX IS
OVER	BUT NOT OVER		MOUNT VER	PLUS*
\$0	\$14,910	1.100%	\$0	\$0.00
\$14,910	\$35,352	2.200%	\$14,910	\$164.01
\$35,352	\$55,794	4.400%	\$35,352	\$613.73
\$55,794	\$77,452	6.600%	\$55,794	\$1,513.18
\$77,452	\$97,884	8.800%	\$77,452	\$2,942.61
\$97,884	\$500,000	10.230%	\$97,884	\$4,740.63
\$500,000	\$600,000	11.330%	\$500,000	\$45,877.10
\$600,000	\$1,000,000	12.430%	\$600,000	\$57,207.10
\$1,000,000	and over	14.630%	\$1,000,000	\$106,927.10

UNMARRIED HEAD OF HOUSEHOLD TAXPAYERS				
IF THE TAXABL	E INCOME IS	COMPUTED TA	X IS	
OVER	BUT NOT OVER		MOUNT ER	PLUS*
\$0	\$14,920	1.100%	\$0	\$0.00
\$14,920	\$35,351	2.200%	\$14,920	\$164.12
\$35,351	\$45,571	4.400%	\$35,351	\$613.60
\$45,571	\$56,400	6.600%	\$45,571	\$1,063.28
\$56,400	\$66,618	8.800%	\$56,400	\$1,777.99
\$66,618	\$340,000	10.230%	\$66,618	\$2,677.17
\$340,000	\$408,000	11.330%	\$340,000	\$30,644.15
\$408,000	\$680,000	12.430%	\$408,000	\$38,348.55
\$680,000	\$1,000,000	13.530%	\$680,000	\$72.158.15
\$1,000,000	and over	14.630%	\$1,000,000	\$115,454.15

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL FRANCHISE TAX BOARD:

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES 800-852-5711 (voice) 800-822-6268 (TTY)

IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free) 916-845-6500

The DE 4 information is collected for purposes of administering the Personal Income Tax law and under the authority of Title 22 of the California Code of Regulations and the Revenue and Taxation Code, including Section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California income tax return.

DE 4 Rev. 41 (1-13) (INTERNET)

^{*}marginal tax

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

STATEMENT TO EMPLOYEES

DRUG-FREE WORK PLACE POLICY

The Foothill—De Anza Community College District, in compliance with federal law, is providing all employees including student employees with the following statement regarding the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance in the workplace.

Any employee convicted of a violation of any federal or state criminal drug statute is required to report that conviction to the Director of Human Resources within 5 days of the conviction.

Definitions:

The term "Workplace" is any location where an employee performs assigned duties on behalf of the District.

The term "Controlled Substance" means a controlled substance defined in Schedules I through V of Section 202 of the Controlled Substances Act, 21 U.S.C. 812.

The term "Controlled Substance Offense," as used in Education Code Section 87405, means any one or more of the following offenses:

- A. Any offense in Sections 11350 to 11355, inclusive, (offenses involving controlled substances formerly classified as narcotics), 11366 (opening or maintenance of unlawful places), 11368 (forged or altered prescriptions), 11377 to 11382, inclusive, (offenses involving controlled substances formerly classified as restricted dangerous drugs), and 11550 (unlawful acts) of the California Health and Safety Code.
- B. Any offenses committed or attempted in any other state or against the laws of the United States, which if committed or attempted in this state, would have been punished as one or more of the abovementioned offenses.
- C. Any offense committed under former Sections 11500 to 11503, inclusive, 11557, 11715, and 11721 of the California Health and Safety Code.
- D. Any attempt to commit any of the above-mentioned offenses.

The term "conviction" means a finding of guilt, including a plea of nolo contendere, or an imposition of sentence or both by any judicial body charges with the responsibility to determine violations of federal or state criminal drug statutes.

District Policy:

It is the policy of the District to impose appropriate disciplinary sanctions on employees for the unlawful possession, use or distribution of illicit drugs or alcohol. Appropriate disciplinary sanctions may result in the District requiring the employee to participate satisfactory in a drug-abuse assistance or rehabilitation program and may also include suspension or termination. The standards of conduct and sanctions applicable to employees are contained in the Foothill-De Anza Community College Board policy number 4500 and in the applicable collective bargaining agreements or employee handbooks.

Dangers of Drugs in the Workplace:

The use of drugs and alcohol may pose significant health risks, dependency, disability and death, and may result in apathy, impaired judgment, lack of concentration and coordination, absenteeism, injuries, illness, ineffective supervision and destruction of property.

Available Assistance:

If you are a full-time employee, drug and alcohol counseling is available to you through the District's Employee Assistance Program. Information is available from the Human Resources Office. All employees can receive information on referrals to drug or alcohol counseling and rehabilitation programs from the Health Offices at both Foothill and De Anza Colleges.

Please print and sign below and return this form to the designated department as follows:

Status:			Return To:	
	•	Full-time contract employees (Faculty, Classified, Administrative, Supervisor, Confidential)	_	Office of Human Resources
	•	Casual hourly employees	_	Office of Human Resources
	•	Part-time faculty	_	Administrative Services at the campus at which you were hired
	•	Student employees	_	Financial Aid Office at the campus at which you were hired
EN	ILO	YMENT STATUS:		
	CL	ASSIFIED		
	FU	ILL-TIME FACULTY		
	AΓ	DMINISTRATIVE		
	SU	PERVISOR		
	CC	ONFIDENTIAL		
	PA	RT-TIME FACULTY		
	CA	ASUAL/TEMPORARY		
	ST	UDENT EMPLOYEE		
I ha	ave r	read the "Statement to Employees" regarding	ng the	District's Drug-Free Workplace Policy.
Pri	nt N	ame		
 Sig	natu	re		
	te			



DATE: December 11, 2007

TO: All Employees

FROM: Marsha Kelly, Director of Risk Management

SUBJECT: INJURY AND ILLNESS PREVENTION

General Safety Guidelines

Foothill-De Anza Community College District has an illness and injury prevention program. This program is intended to provide a safe productive work environment. Each employee receives a copy of the attached General Safety Guidelines and signs a verification that he/she understands the program and will comply with it. Please note that these general safety guidelines apply to all employees of the District. Your department may have additional safety considerations. Please check with your supervisor concerning such requirements.

Work Injuries:

In the event of an on-the-job injury, all District employees must first report to the Campus Health Services Office. If Health Services is closed or if the injury requires further medical treatment, employees must go for initial diagnosis and treatment to:

Cupertino Medical Center (CMC) Occupational Medicine 10050 Bubb Rd Cupertino, CA 95014-4132 Phone: (408) 996-8656 Fax: (408) 996-7465 Hours of Operation: Monday – Friday 8 a.m. to 5 p.m.

Your personal medical doctor may not treat you unless you have placed a memo in your personnel file prior to the injury denoting treatment by your named physician. In the event of a major medical emergency requiring immediate attention, please go to the nearest emergency center, hospital or clinic. Thank you for your cooperation. If you have any questions or comments, please do not hesitate to contact the Risk Management Office at extension 6131.

FOOTHILL-DEANZA COMMUNITY COLLEGE DISTRICT GENERAL SAFETY GUIDELINES

- 1. All work related injuries and illness must be reported to the immediate supervisor as soon as possible after an employee becomes aware of the injury or illness.
- 2. Employees shall use extreme care and consideration in the performing their duties to see that they do not cause injury to others or create work hazards that could cause injury to others.
- 3. Employees should not attempt to lift heavy or bulky objects. Doing so could cause injury to the back or other body parts. When in doubt, please seek assistance from Plant Services (Ext. 6156), or Custodial Services on your campus.
- 4. Personal equipment, such as extension cords, chemicals, or electrical heaters should not be brought to the school without the permission of your supervisor or Plant Services.
- 5. Using electrical heaters to provide warmth for extended periods of time can cause building fires. Employees are discouraged from using electric heaters. Alternative means should be found for providing building heat over the cooler months.
- 6. Plant Services (Ext. 6122) must be notified as soon as possible if a fire extinguisher has been used, so that it can be recharged or replaced.
- 7. When a piece of equipment or a facility becomes defective, it should either be removed from service or reported to department technicians or Plant Services so that repairs can be made. Failure to report faulty conditions can result in injuries. A "Safety Report" form is included with this packet.
- 8. Food and liquid spills must be wiped up immediately.
- 9. Employees should never attempt to repair electrical equipment or appliances. Defective equipment should be removed from service and technicians notified to make the proper repairs.
- 10. Cabinets can be very dangerous if used improperly. Opening two drawers simultaneously can cause a file cabinet to crash to the floor. Whenever possible, cabinets should be bolted together in tandem or secured to the wall.
- 11. Flammable liquids such as duplicating fluid should always be stored in appropriate, closed containers. Large supplies should be stored in UL-approved cabinets or by other appropriate means described by the fire department. If in doubt, call Dave Paulsen (6122). Flammable liquids should never be left out on an open counter, an earthquake could cause a spill or possible fire. All storage should be ventilated to the outside.
- 12. For earthquake safety, heavy objects should be stored on lower shelves while lighter and less dangerous items can be stored on middle and upper shelves.
- 13. Bookshelves, storage cabinets, and other elevated storage areas should be well secured, securely bolted to the wall, or secured as a unit in such a way to reduce tipping in an earthquake.
- 14. Defective furniture, worn carpets, defective stairs, loose handrails, and other facilities defects that create accident hazards should be reported to Plant Services so repairs can be completed. If possible, remove the object from service.
- 15. Extension cords/electrical cords should never be run under rugs or floor mats.

FOOTHILL-DEANZA COMMUNITY COLLEGE DISTRICT GENERAL SAFETY GUIDELINES (continued)

- 16. All employees should take the time BEFORE an emergency to read the emergency procedures in place for responding to fires, earthquakes, or first aid emergencies. Flip charts of emergency procedures and are posted in classrooms and offices throughout the district.
- 17. Hazard communication where individuals must use chemicals and toxic materials in the course of their work is an important responsibility dictated by CAL OSHA. The Hazard Communication law dictates that Material Safety Data Sheets (MSDS) be kept in the work area, and be easily accessible for ready reference.
 - All employees who work with or around hazardous materials should be familiar with the requirements and responsibilities of the management of hazardous materials as indicated in the department's Hazardous Materials Management Plan. Questions about hazardous materials should be directed to District Fire and Safety Technician (Extension 6122).
- 18. All employees should know the location of fire extinguishers and have some familiarity with their use. If necessary, specific training can be given by District Fire and Safety Technician, Dave Paulsen (Extension 6122).
- 19. Employees should NEVER eat, drink or use personal items in the lab areas.

FOOTHILL - DE ANZA COMMUNITY COLLEGE DISTRICT

SAFETY REPORT

DATE:		SUBI	MITTED BY			,
				Į.	(Optional)	
CONCE	RN OR HAZARI	D;		٠		
LOCATIO	DN: (Be as spe	cific as pos	sible)		•	
SUGGES	TED REMEDY:	· .				
··						
REPORTE	D BY:					
•		(Optio	nal)			
Send to R	isk Manager, Di					
FOR PLAN	T SERVICES US				eator if namo i	
ATE RECE	•	· ·	J	to 0.1911	ator ir name r	riciaded)
INDINGS:		, · ·				
CTION:	Work Order					
	Plant Services:					

FOOTHILL-DEANZA COMMUNITY COLLEGE DISTRICT GENERAL SAFETY GUIDELINES (continued)

obligated to follow them in my work a	activities.	L 1
Signature	-	
Print Name	Date:	- .
Campus	_Department	_

I have received, read, and understand the General Safety Guidelines. I also understand that I am

IMPORTANT

PLEASE SIGN AND DATE THIS SIGNATURE PAGE AND RETURN IT TO PERSONNEL AT THE DISTRICT OFFICE. IT IS REQUIRED TO BE RETAINED IN YOUR PERSONNEL FILE.

Please circle one: Administrative Faculty (PT) (FT) Classified Casual Student



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

RETIREMENT PLAN INFORMATION/ELECTION FORM

It is important that you provide accurate information regarding your current retirement status. This information is used to determine appropriate payroll deductions.

Please answer the following que	stions:			YES	NO	
A. Are you a current member of Cal (i.e., Do you still have an active acco						
If so, what is your ID numl	oer under t	the Retirer	nent System?*			
B. Are you a current member of Cal (i.e., Do you still have an active acco						
If so, what is your ID numl	oer under t	the Retirer	nent System?**			
C. Are you a retired annuitant (retire	C. Are you a retired annuitant (retiree) under STRS?					
If so, what is your ID numl	oer under t	the Retirer	ment System?*			
D. Are you a retired annuitant (retiree) under PERS?						
If so, what is your ID numl	oer under t	the Retirer	ment System?**			
E. Have you withdrawn your funds f	rom STRS	?				
F. Have you withdrawn your funds f	rom PERS	;?				
If you need to find your ID Number, please cont	tact the app	ropriate age	ency: <u>*CalPERS:</u> (888) 225-7377 or <u>**Calpers</u>	alSTRS: (80	00) 228-545	
Current Employment Status:						
List other schools/districts that you are now employed by:	Full- Time	Part- Time	Employer Contact Information (address and phone)			
1.						
2.						
NOTE: It is the employee's respon	nsibility to	notify the	District of any changes in his/her ret	irement sta	atus.	
Employee Signature			Social Security Number (last four	digits)		
Name (please print)			Date			

Recipient Designation Form-Information

One-Time Death Benefit/Cash Balance Lump-Sum Payment

To be valid, this form must be received and accepted by CalSTRS before your death.

The Recipient Designation form replaces the One-Time Death Benefit Recipient form and the Cash Balance Beneficiary Designation form. If you have one of these forms currently on file with CalSTRS, you do not need to submit a new Recipient Designation form unless you wish to make a change to your recipient designation.

DEFINED BENEFIT PROGRAM MEMBERS

Use this form to designate recipients to receive the onetime benefit that may be payable in the event of your death. If you are an active member at the time of your death, any accumulated contributions in your account will be paid to your designated recipients only if you did not elect an option beneficiary to receive a continuing benefit after your death, or you have no spouse, registered domestic partner or children eligible to receive a family or survivor benefit allowance after your death.

If your death occurs before retirement, your recipients may be eligible to receive the balance in your Defined Benefit Supplement account as an ongoing annuity or a lumpsum payment. If your death occurs after retirement, your recipients may be eligible for the ongoing annuity you elected at retirement.

This form will not protect your survivor with a lifetime benefit. To provide your survivors with a lifetime benefit, submit the *Preretirement Election of Option* form when you are eligible to retire.

CASH BALANCE BENEFIT PROGRAM PARTICIPANTS

Use this form to designate recipients to receive the benefit in the event of your death.

If you are receiving an annuity at the time of your death, the benefit payable is determined based on the annuity you elected.

If your recipient's (other than an entity) share of your account balance is at least \$3,500, he or she may elect to receive an annuity in place of a lump-sum payment.

IMPORTANT FACTS

- This form remains in effect until either you submit another valid *Recipient Designation* form, or your membership in CalSTRS is terminated by a refund of your accumulated contributions. *It is important to keep this form current.*
- If your designated primary recipients predecease you, any benefit due will be paid to your secondary recipients, unless you submit a valid *Recipient Designation* form designating new recipients. If we are unable to locate your designated recipients, the death benefit will be distributed to the best of our ability according to the laws in existence at the time of your death.
- If you do not have a valid *Recipient Designation* form on file with CalSTRS before your death or if all your designated recipients predecease you, any benefit due will be paid to your estate.
- You may change your recipient designations at any time—before or after retirement. There is no fee or financial penalty for changing your designation.

QUESTIONS

E-mail us at CalSTRS.com/contactus or call 800-228-5453.

This form is available at CalSTRS.com (select *Forms* & *Publications*).

Return your completed form to:

CalSTRS P.O. Box 15275, MS 43 Sacramento, CA 95851-0275

Recipient Designation Form-Instructions

One-Time Death Benefit/Cash Balance Lump-Sum Payment

Print clearly in dark ink or type all information requested. Initial all corrections on the form.

Check the appropriate box to identify your CalSTRS membership status.

If you are both a Defined Benefit Program member and Cash Balance Benefit Program participant and you are designating different recipients for each, you must complete two separate *Recipient Designation* forms.

SECTION 1: MEMBER/PARTICIPANT INFORMATION

Enter your full name, Client ID or Social Security number, complete mailing address, birth date, telephone number and e-mail address.

SECTIONS 2 AND 3: PRIMARY AND SECONDARY RECIPIENTS OR TRUST

You may name a living person, an estate, a trust, a corporation, a charitable organization, a parochial institution or a public entity as your recipient.

- **Persons**—Provide full name, address, telephone number, Social Security number, birth date and relationship.
- Organization—To designate an organization, check the box and enter the name and address of the organization and the organization's tax identification number. Include organization contact information whenever possible.
- Trust—To designate a trust, check the box and enter the full name of the trust, the trustee's name and address, and the date the trust was created. CalSTRS will contact the trustee and pay benefits to the trust. You do not need to provide the trust document at this time.

• Estate—To designate your estate, check the box and enter "My Estate" for the recipient's name. Upon your death, if your estate is not subject to probate, CalSTRS will pay benefits pursuant to California Probate Code section 13101.

Check the box on page 3 if additional recipients are listed on an attachment. Identify each as *primary* or *secondary*.

You may designate a percentage for each recipient. If you use percentages, the total must equal 100 percent for the primary recipient section and/or secondary recipient section.

SECTION 4: REQUIRED SIGNATURES

You must sign and date your form. If you are married or registered as a domestic partner, your spouse or partner must also sign and date your form acknowledging your recipients and provide his or her Social Security number and date of birth.

If your spouse or registered domestic partner does not sign your form, you must complete the *Justification for Non-Signature of Spouse or Registered Domestic Partner.*

Failure to have the required signatures will result in the rejection of your *Recipient Designation* form.

If you divorced or terminated a registered domestic partnership and a portion of your CalSTRS benefits was awarded to a former spouse or partner, check the box that indicates this. You may need to refer to your settlement agreement. In addition, if your court documents have not been reviewed by CalSTRS, you may be asked to provide them.

Recipient Designation Form

One-Time Death Benefit/Cash Balance Lump-Sum Payment

(MS 0002, rev. 01/11)

CALSTRS

California State Teachers' Retirement System
P.O. Box 15275, MS 43
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

Benefit Program and the Cash Balance Benefit Program. Print of	ofits payable in the event of your death under the CalSTRS Defined clearly in dark ink or type all information requested and initial any					
corrections. Check one of the following:						
_	nt designation is for the one-time death benefit payable upon					
I am a participant of the Cash Balance Benefit Program. My recipient designation is for the lump-sum payment to be distributed upon my death.						
I am a member/participant of both the Defined Benefit and Cash Balance programs. My recipient designation is for the lump-sum death benefits payable under both programs. (Refer to instructions if recipients are different between programs.)						
death. If I survive the primary recipients, I designate the second	fits payable under the Teachers' Retirement Law at the time of my lary recipients—or their survivors—to share equally unless otherwise my death. If I survive all of my named recipients, then any benefit					
Return your signed form to: CalSTRS • P.O. Box 15275, MS 43	3 ● Sacramento, CA 95851-0275					
Section 1: Member/Participant Information						
NAME (LAST, FIRST, INITIAL)	CLIENT ID OR SOCIAL SECURITY NUMBER					
MAILING ADDRESS	DATE OF BIRTH (MM/DD/YYYY) ()					
CITY STATE ZIP CODE	HOME TELEPHONE					
E-MAIL ADDRESS						
Section 2: Primary Recipients						
Use this area to designate one or more <i>primary</i> recipient Use additional sheets if needed.	its to receive a death benefit.					
FULL NAME OF PERSON, TRUST OR ORGANIZATION	()					
MAILING ADDRESS	TELEPHONE					
CITY	STATE ZIP CODE					
Person – Relationship:						
☐ Person - Relationship:	SOCIAL SECURITY NUMBER/TAXPAYER ID NUMBER/EMPLOYER ID NUMBER					
Organization – Contact Name:	DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)					
☐ Trust	DEDCENTAGE					
☐ Estate	PERCENTAGE (MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)					



Recipient Designation Form continued



Section 2: Primary Recipients continued		
FULL NAME OF PERSON, TRUST OR ORGANIZATION		()
MAILING ADDRESS		TELEPHONE
CITY	STATE	ZIP CODE
Person – Relationship: Male Female	SOCIAL SECURIT	Y NUMBER/TIN/EIN
Organization - Contact Name:	— DATE OF BIRTH/T	RUST DATE (MM/DD/YYYY)
□Trust	DATE OF BITTING	TIOOT BY TE (WIW/DB/TTTT)
☐ Estate	PERCENTAGE (MUST TOTAL 100)% FOR ALL PRIMARY RECIPIENTS)
FULL NAME OF PERSON, TRUST OR ORGANIZATION		()
MAILING ADDRESS		TELEPHONE
CITY	STATE	ZIP CODE
Person – Relationship:		
Male Female	SOCIAL SECURIT	Y NUMBER/TIN/EIN
Organization - Contact Name:		RUST DATE (MM/DD/YYYY)
□Trust	DATE OF BINTH/T	NOST DATE (WIIVIDD/TTTT)
☐ Estate	PERCENTAGE (MUST TOTAL 100)% FOR ALL PRIMARY RECIPIENTS)
Section 3: Secondary Recipients		
Use this area to designate one or more secondary re	ecipients to receive a	death benefit should all of your
primary recipients predecease you. Use additional s		,
FULL NAME OF PERSON, TRUST OR ORGANIZATION		
TOLE NAME OF FERIOUN, THOST OF CHUANZATION		()
MAILING ADDRESS		TELEPHONE
CITY	STATE	ZIP CODE
December Deletionalism		
☐ Person – Relationship:	SOCIAL SECURIT	Y NUMBER/TIN/EIN
Organization - Contact Name:	DATE OF DIDT: 17	DUOT DATE ANALODAGGG
☐ Trust	— DATE OF BIRTH/T	RUST DATE (MM/DD/YYYY)
☐ Estate	PERCENTAGE	
	(MUST TOTAL 100)% FOR ALL SECONDARY RECIPIENTS)

Recipient Designation Form continued



Section 3: Secondary Recipients continued					
FULL NAME OF PERSON, TRUST OR ORGANIZATION					
MAILING ADDRESS	TELEPHONE				
	27175				
CITY	STATE ZIP CODE				
Person – Relationship:					
☐ Male ☐ Female	SOCIAL SECURITY NUMBER/TIN/EIN				
Organization – Contact Name:	DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)				
□Trust					
☐ Estate	PERCENTAGE (MUST TOTAL 100% FOR ALL SECONDARY RECIPIENTS)				
☐ Check this box if additional recipients are listed on an a	attachment. Identify each as <i>primary</i> or secondary.				
Section 4: Required Signatures					
Check all that apply.					
 I am married or registered as a domestic partner and both our signatures are below. I am married or registered as a domestic partner and my spouse or partner did not sign below. I have completed and signed the Justification for Non-Signature of Spouse or Registered Domestic Partner section on the next page. I have never been married or in a registered domestic partnership, or I am widowed or my partner has died. I have been divorced or terminated a registered domestic partnership and my former spouse or partner was awarded a portion of my CalSTRS benefits. I have been divorced or have terminated a registered domestic partnership and my former spouse or partner was not awarded a portion of my CalSTRS benefits. 					
I certify under penalty of perjury under the laws of the Stat I understand that perjury is punishable by imprisonment fo					
I understand it is a crime to fail to disclose a material fact of for the purpose of altering a benefit administered by CalST up to one year in jail and a fine of up to \$5,000 (Education CalCalCalCalCalCalCalCalCalCalCal	RS and it may result in penalties, including restitution,				
MEMBER'S SIGNATURE	DATE (MM/DD/YYYY)				
SPOUSE'S OR REGISTERED DOMESTIC PARTNER'S SIGNATURE	DATE (MM/DD/YYYY)				
SPOUSE'S OR PARTNER'S NAME (LAST, FIRST, INITIAL)					
SPOUSE'S OR PARTNER'S SOCIAL SECURITY NUMBER	SPOUSE'S OR PARTNER'S DATE OF BIRTH (MM/DD/YYYY)				

Recipient Designation Form continued



Justification for Non-Signature of Spouse of Regis	ici cu Duilicsuc Fai ilici
As required by Education Code sections 22453 and 26703, any requestion which spousal or registered domestic partner interest may be presedomestic partner unless one of the following conditions exist. If you are spouse or partner does not sign this form, you must check the appropriate not sign.	ent requires the signature of the spouse or registered remarried or registered as a domestic partner and your
 □ I do not know and have taken all reasonable steps to determine the domestic partner. □ My spouse or registered domestic partner is incapable of executing incapacitating mental or physical condition. □ My current spouse or registered domestic partner has no identifiated. □ My spouse or registered domestic partner and I have executed as a community property law inapplicable to the marriage or registered. □ My spouse or registered domestic partner has refused to sign the to enforce or waive the signature requirement for my spouse or partner before any designation can be made. Submit a certified copy sections 22454 and 26704 	g the acknowledgment because of an ole community property interest in the benefits. Settlement agreement that makes the domestic partnership. acknowledgment. Court action will be or has been initiated ortner. (CalSTRS must have a certified copy of the court
I certify under penalty of perjury under the laws of the State of I understand that perjury is punishable by imprisonment for up	
	to four years (Penal Code section 126). make any knowingly false material statements for it may result in penalties, including restitution, up to
I understand that perjury is punishable by imprisonment for up I understand it is a crime to fail to disclose a material fact or to the purpose of altering a benefit administered by CalSTRS and	to four years (Penal Code section 126). make any knowingly false material statements for it may result in penalties, including restitution, up to
I understand that perjury is punishable by imprisonment for up I understand it is a crime to fail to disclose a material fact or to the purpose of altering a benefit administered by CalSTRS and one year in jail and a fine of up to \$5,000 (Education Code section)	to four years (Penal Code section 126). make any knowingly false material statements for it may result in penalties, including restitution, up to on 22010). SIGNATURE DATE (MM/DD/YYYY) ed and will be returned to you. Your current
I understand that perjury is punishable by imprisonment for up I understand it is a crime to fail to disclose a material fact or to the purpose of altering a benefit administered by CalSTRS and one year in jail and a fine of up to \$5,000 (Education Code section MEMBER'S SIGNATURE If this form is not completely filled out, it will not be accept	make any knowingly false material statements for it may result in penalties, including restitution, up to ion 22010). SIGNATURE DATE (MM/DD/YYYY) ed and will be returned to you. Your current fully before submitting: ride all the requested information? late the trust was created? Do not provide your trust to for your primary recipients and/or secondary



RETIREMENT SYSTEM ELECTION

Read the attached instructions and information for retirement system coverage before completing t	he
Retirement System Election. Keep a copy of the instructions and information sheet for your record	ls.
Please use a black ink pen or download and print the form.	

TELEPHONE NUMBERS:

TOLL FREE 1-800-228-5453

MAILING ADDRESS:

CalSTRS MAIL STATION #16 P.O. BOX 15275 SACRAMENTO, CA 95851-0275

(ES 372 05/09)

INSTRUCTIONS AND INFORMATION FOR RETIREMENT SYSTEM ELECTION

The following instructions are to assist you and your employer in completing the Retirement System Election (Form # ES 372). The first section of the form must be completed by you with assistance from your employer. Please complete all entries above the Employer Certification section. By signing this document, you understand it is a crime to fail to disclose a material fact or to make any knowingly false material statements for the purpose of altering a benefit administered by CalSTRS and it may result in up to one year in jail and a fine of up to \$5,000. Ed. Code §22010

EMPLOYEE INSTRUCTIONS

- I. Press firmly and print clearly with **DARK INK**, or type all information requested. Do not use light colors of ink, pencil, felt pen, or erasable ink.
- II. If you should make a mistake on the Retirement System Election form, line through the error and initial.
- III. Enter your full name, last four digits of your Social Security Number, effective date of the change in employment status and position type.
- IV. **EFFECTIVE DATE** is the first date that service was or will be performed in the new position.
- V. **RETIREMENT SYSTEM COVERAGE** If you are a member of CalSTRS and have accepted employment to perform service that requires membership in CalPERS, enter an "X" in the box next to the coverage you elect. If you are a member of CalPERS and have accepted employment to perform service that requires membership in CalSTRS, enter an "X" in the box next to the coverage you elect.
- VI. **EMPLOYEE SIGNATURE** Sign and date the Retirement System Election form.
- VII. SUBMIT the Retirement System Election form to your employer. Retain a copy for your records.

For further information, you may contact our office toll Free 1-800-228-5453, or by writing us at the address on the cover page.

Should you find it necessary to contact us, your correspondence should include the last four digits of your Social Security number, full name, address, and daytime telephone number.

EMPLOYER INSTRUCTIONS

Please complete the EMPLOYER CERTIFICATION only after the employee has completed the required employee information. Employees must qualify for membership before they can elect.

CO/DIST CODE/STATE DEPARTMENT – Enter the appropriate county and district codes. Example: Kern County, Edison Elementary would be 15-012, CA Department of Education 59-174.

EMPLOYER CERTIFICATION - Print official's name, title and phone number, sign and date the Retirement System Election form.

SUBMIT the completed Retirement System Election form to the County Office of Education or if you represent a state department, send it directly to CalSTRS and send a copy to CalPERS.

COUNTY OFFICE OF EDUCATION

Review, sign and date the Retirement System Election form.

Mail the original Retirement System Election form to the retirement system elected by the employee and a copy to the retirement system that would normally cover the service. Provide copies for the employer, employee and employee's file.

INFORMATION

A member of the CalSTRS Defined Benefit Program who becomes employed by a school district, a community college district, a county superintendent of schools or limited state departments to perform service that requires membership by the California Public Employees' Retirement System (CalPERS) [Education Code section 22508(a)]may elect to receive credit under the CalSTRS Defined Benefit Program for such service by submitting a Retirement System Election form to CalSTRS, within 60 days of the effective date of employment in the position requiring membership in the other system. If the CalSTRS member does not elect to continue as a member of CalSTRS, all service subject to coverage by CalPERS will be reported to that retirement system. (Education Code 22508)

A member of CalPERS who was employed by a school employer, Board of Governors of California Community Colleges, or State Department of Education or has at least five years of CalPERS credited service and who accepts employment to perform creditable service that requires membership by the CalSTRS Defined Benefit Program [Government Code section 20309 (a)] may elect to receive credit under CalPERS for such service by submitting a Retirement System Election form to CalPERS, within 60 days of the effective date of employment in the position requiring membership in the other system. If the CalPERS member does not elect to continue as a member of CalPERS, all CalSTRS creditable service will be reported to CalSTRS. (Government Code 20309)



RETIREMENT SYSTEM ELECTION ES 372 (05/09)

PLEASE READ THE AT		ONS				
BEFORE COMPLETING THIS FORM PLEASE TYPE OR PRINT LEGIBLY IN DARK INK				CalSTRS USE ONLY		
TO BE COMPLETED BY EMPLOYE					IKS USE ONL	1
Name: (Last)	(First)	(Initia			y Number: (last	four digits)
, ,		,			•	<i>C</i> ,
EFFECTIVE DATE (Mo/Day/Yr)	DOCITION THE E					
EFFECTIVE DATE (Mo/Day/11)	POSITION TITLE					
	Credentiale	d		Classified		State Service
Employment in the California public school system is generally subject to coverage by either the California State Teachers' Retirement System (CalSTRS) or the California Public Employees' Retirement System (CalPERS). Employment in a position to perform "creditable service," as defined in Education Code Section 22119.5, is usually credited in CalSTRS, while classified (non-certificated) employment is usually credited in CalPERS.					on Code Section	
A member of CalSTRS who becomes employed state employment, as defined in Education Code CalPERS unless he/she files a written election (v	Section 22508, to perform se	ervice that require	s member	rship in CalPERS will	have that service	credited with
A member of CalPERS who is employed by a so five years of CalPERS credited service, as define requires membership in CalSTRS, will have that position) to have the service credited with CalPE	ed in Government Code Secti service credited with CalST	ion 20309, and wh	no subseq	uently becomes emplo	oyed to perform cr	editable service that
service that requires membership in CalPERS but you may elect to continue retirement system coverage under CalSTRS. Please enter an "X" in the box next to the coverage you elect. CALIF STATE TEACHERS' RETIREMENT SYSTEM CALIF STATE TEACHERS' RETIREMENT SYSTEM			nber of CalPERS wh uires membership in C CalPERS. Please ent lect. LIF PUBLIC EMPLOY	CalSTRS but you rer an "X" in the boxYEES' RETIREME	nay elect to continue ox next to the NT SYSTEM*	
		·				
I fully understand that this election i	s irrevocable for this	employer.				
EMPLOYEE GLOSS EVEN				D. A. WEE		
EMPLOYEE SIGNATURE				DATE		
EMPLOYER CERTIFICATION I certify that the employee meets the qualifications to make a retirement system election.						
CO/DIST/STATE DEPT NAME			CO/DIST COI	DE OR STATE I	DEPT	
SCHOOL/STATE OFFICIAL'S NAME and PHONE NUMBER			TITLE	TITLE		
SIGNATURE OF SCHOOL/STATE OFFICIAL			DATE			
COUNTY OFFICIAL'S NAME and PHONE NUMBER				TITLE		
SIGNATURE OF COUNTY OFFICIAL				DATE		
*CalPERS Employer Code:						
Can Erro Employer Code.	111					



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

Foothill-De Anza Community College District is required to provide you this notice, *Form SSA-1945*, to read and sign at the beginning of your employment with our District. We are required to do so under federal law, Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004.

This notice must be provided to you because you are employed in a position in which neither you as employee nor Foothill-De Anza Community College District as the employer will be contributing to Social Security.

You must do the following:

- Read the notice
- Sign the notice
- Return the notice to the Human Resources office

What is the purpose of the notice?

The purpose of the notice is to inform you that your Social Security benefits may be impacted. This can be a complicated issue. You may want to check the Social Security website at www.socialsecurity.gov and/or see your tax consultant, accountant or attorney for advice to determine whether the laws mentioned in the notice pertain to you

Why will I not be in Social Security?

Not all employees are required to be in Social Security. Instead of being in Social Security certain employees participate in alternative programs such as the CalSTRS retirement program.

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name:	Employee ID #		
Employer Name: Foothill-De Anza CCD	Employer ID# <u>94-1597718</u>		
Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.			
Windfall Elimination Provision Under the Windfall Elimination Provision, your Social Security figured using a modified formula when you are also entitled to a per pay Social Security tax. As a result, you will receive a lower Social not entitled to a pension from this job. For example, if you are age reduction in your Social Security benefit as a result of this proupdated annually. This provision reduces, but does not totally eliminate For additional information, please refer to the Social Security Provision."	ension from a job where you did not al Security benefit than if you were e 62 in 2005, the maximum monthly ovision is \$313.50. This amount is ninate, your Social Security benefit.		
Government Pension Offset Provision Under the Government Pension Offset Provision, any Social Security which you become entitled will be offset if you also receive a pension based on work where you did not pay Social Security tax your Social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) benefit by two-thirds of the social Security spouse or widow(er) by two-thirds of the social Security spouse or widow(er) by two-thirds of the social Security spouse or widow(er) by two-thirds of the social Security spouse or widow(er) by two-thirds of the social Security spouse or widow(er) by two-thirds of the social Security spouse or widow(er) by two-thirds of the social Security spouse or widow(er) by two-thirds of the social Security spouse or widow(er) by two-thir	Federal, State or local government x. The offset reduces the amount of		
For example, if you get a monthly pension of \$600 based on earning Security, two-thirds of that amount, \$400, is used to offset your Security, the security are eligible for a \$500 widow(er) benefit, you will be Security, \$500 - \$400 = \$100. Even if your pension is high enough widow(er) Social Security benefit, you are still eligible for Mainformation, please refer to the Social Security publication, "Government of the security publication,"	Social Security spouse or widow(er) receive \$100 per month from Social ugh to totally offset your spouse or ledicare at age 65. For additional		
For More Information Social Security publications and additional information, includir each provision, are available at www.socialsecurity.gov . You may or, for the deaf or hard of hearing, call the TTY number 1-800-32. Security office.	also call toll free 1-800-772-1213 ,		
I certify that I have received Form SSA-1945 that contains info of the Windfall Elimination Provision and the Government potential future Social Security benefits.			

_Date_____

Signature of Employee _____





Foothill-De Anza Faculty Association

12345 El Monte Road, Los Altos, CA 94022

WELCOME

Welcome to the new faculty of Foothill and De Anza colleges. You will be working in an outstanding community college district, a pioneer and pacesetter in all forms of programs from remediation to high technology. The Foothill-De Anza District employs nearly 2,000 people, among them 455 full-time faculty and about 700 part-time faculty. Our superb faculty is one very good reason why this district enjoys a national reputation for academic excellence.



Officially, the name of the faculty bargaining group is "Foothill-De Anza Faculty Association," but most people simply use the initials "FA" when speaking of the organization. The FA and trustees collectively bargain decisions on salary, hours of work, academic calendar, hiring practices, class size and other terms and conditions of

EA is a locally governed, independent association which was incorporated in 1977 by the non-management professional educators here in this college district to represent themselves pursuant to the California Public Employment Relations Act of 1976. While most faculty members individually support the statewide Faculty Association of the California Community Colleges (FACCC), EA has no affiliation with any state/national collective bargaining agent.

We at FA sincerely hope that your work at Foothill-De Anza is rewarding and joyful.

While nearly all faculty are members of FA, no one is required to be a member. But if you choose not to join, you must nevertheless pay the organization a service fee equal to membership dues. This is a condition of employment in the Foothill-De Anza Community College District. When District faculty voted to create their own representation organization, they also voted to share equitably the expense of operating a bargaining group. Thus the faculty and the trustees of the District negotiated a provision in their employment contract that requires each faculty member to either join FA, or to remain a non-member, but pay a service fee equal to regular membership dues. Please see Article 4 of the Agreement between FA and the District for details about membership options.

THE PART-TIME FACILTY

Part-time faculty are a major interest to FA. The contract provides them with a salary schedule ranked among the highest statewide and a unique seniority system. In addition, part-time faculty are entitled to personal necessity and sick leave and special pay for meetings they are required to attend. A contract provision makes part-time faculty eligible to apply for partial reimbursement for attendance at professional conferences in their field. FA maintains a standing part-time committee and routinely appoints at least one part-time faculty member to the FA negotiating team. And, of course, part-time faculty are eligible to run for any EA office.

FA maintains 10 standing committees, largely staffed by faculty volunteers, and appoints representatives to nearly all major college and District committees, including the Academic Senates, curriculum committees, college councils, and the Chancellor's Council.

The Association's conciliation and grievance team performs an especially valuable service. When, as sometimes happens, faculty members have differences with representatives of the Board of Trustees, EA's trained conciliation officers are asked to lend their communication skills in helping to resolve these differences swiftly and to the mutual satisfaction of the parties involved.

THE AGREEMENT

The terms and conditions of faculty employment are governed by contractual provisions negotiated by local faculty members and representatives of the Board of Trustees.

The current contract, or Agreement, Includes 39 articles with such titles as Load and Class Size. Personnel File, Class Cancellation, Part-time Faculty, Summer Sessions, Leaves. Ask at either college's Personnel Office, the District Office, or the FA office for a copy of the

The FA Executive Council is the organization's governing board. There are seventeen seats on the Council. Council members are elected by their colleagues; terms are two years and are staggered. Seats are apportioned to a college according to its number of faculty. Four at-large seats are always reserved for District part-time faculty.

FA's chief executive officer is the president of the Executive Council, who is elected each year by the Council itself. Other key officers are the Council vice-president, the FA chief negotiator and the group's executive secretary.

MESSAGE FROM THE PRESIDENT

"On behalf of FA, welcome to the Foothill-De Anza Community College District. We hope that this is the beginning of a positive and rewarding professional experience. Just as you are committed to providing the best educational experience to your students, FA is committed to a mutual gains approach in working with management to provide you with best possible working environment. EA is here to serve you by representing your Interests at the lating table, assisting you in resolving problems ម៉ែក a non-adversarial manner, and in protecting The rights guaranteed to you in the District-FA ment. We hope that you will choose not only to FA member but also to join a committee or HE FA Executive Council. The success of the organization depends on the energy and vision of professionals like you." Milonas, Faculty Association President

> aken at recent FA Executive Council activities. There annually spend two full days at Asilomar ctive bargaining issues where in-depth talks can

THE FA OFFICE

For the convenience of faculty, <u>FA</u> maintains an office in the District Annex that is open 8:30 a.m. to 5:00 p.m., Monday through Thursday and 8:30 a.m. to noon on Friday. For general information, interpretation of contract articles, or resolution of problems, contact office manager Susanne Elwell (650) 949-7544. All calls are confidential.

A major project of the <u>FA</u> staff is production of the <u>FA</u> News, an award-winning newsletter. Look for it in your mailbox each month.

DUES

<u>FA</u> dues for full-time faculty are six tenths of one percent (0.006) of total gross District salary. Part-time faculty dues are four and a half tenths of one percent (0.0045) of total gross District salary. When a part-timer is not offered an assignment or when a class does not "make," there are no dues for the member. All faculty have chosen payroll deduction as a convenient method for payment to <u>FA</u>. Dues can be increased only upon the vote of the general faculty, both full- and part-time.

MEMBERSHIP INFORMATION

Last Name (print)	First Name	Initial
Street Address	City	Zip
Home Phone	S	ocial Security (last four digits)
Division/Program	Month/Year	first employed by FHDA CCD
Dues Preference: (see "Membership" section)		Part-Time ACCC Membership Benefits: see "Membership" section)
Regular Membership	Service Fee	Accept Decline

DEDUCTION AUTHORIZATION

I hereby authorize and instruct the Foothill-De Anza Community College District to deduct from each salary warrant due me for services as a faculty employee the sum necessary to meet my financial obligation to the Foothill-De Anza Faculty Association pursuant to *Article 4* of the *Agreement* between the Association and the Foothill-De Anza Board of Trustees. The deduction may be increased or decreased according to the regulations of the Association. Pursuant to this authorization, the District has no obligations or liabilities, expressed or implied, beyond the deduction and transmittal of the fee to the Foothill-De Anza Faculty Association.

(Employee Signature)

(Date)

FOOTHILL-DE ANZA FACULTY ASSOCIATION
Foothill College • 12345 El Monte Road • Los Altos Hills • CA 94022
Phone (650) 949-7544 • Fax (650) 941-7322



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

Statement Pursuant To Penal Code Section 11166.5 (Child Abuse Reporting)

Penal Code Section 11166.5 requires as a prerequisite to employment that all persons who enter into employment after January 1, 1985, certify, by signing this statement, that they have knowledge of Penal Code Section 11166 and will comply with its provisions.

Section 11166 of the Penal Code requires any child care custodian, health practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of a child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

"Child care custodian" includes teachers, administrative officers, supervisors of child welfare and attendance, or certificated pupil personal employees of any public or private school; administrators of a public or private day camp; licensed day care workers; administrators of community care facilities licensed to care for children; head-start teachers; licensing workers or licensing evaluators; public assistance workers; employees of a child care institution including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities; and social workers or probation officers.

"Health practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professional Code; state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; marriage, family or child counselors; and religious practitioners who diagnose, examine, or treat children.

No child care custodian, health practitioner, or employee of a child protective agency who reports a known or suspected instance of child abuse shall be subject to any sanction for making the report.

Any person who fails to report an instance of child abuse which he or she knows to exist or reasonably should know to exist, as required by this article, is guilty of a misdemeanor and is punishable by confinement in the county jail for a term not to exceed six months or a fine of one thousand dollars (\$1,000) or by both.

This statement shall be retained by the employer.

I certify that I have read the foregoing, understand the contents thereof, and agree to comply with the provisions of the Penal Code Section 11166.

Employee's Name:	 	
Employee's Signature:	 	
Date:		



LIVESCAN SERVICE AND TB TESTING SCHEDULE

LiveScan (fingerprinting) Service is available on the Foothill College <u>OR</u> De Anza campus. A **time is reserved for you on the day of your New Hire Orientation (unless otherwise noted during orientation)**. You will be given your staff ID card and directed to the LiveScan facility located in the police department in the Foothill College campus center.

Livescan Contact information: Phone: (650) 949-7925

Email: livescan@fhda.edu

TB testing can be done on <u>either</u> the Foothill College or De Anza College campus *on a walk-in basis*.

After the TB test is administered, you must return to get the results read within 48-72 hours. Please reference the contact and schedule information below, and plan accordingly:

Campus	Location and Phone	Test Administered (Day/Time)	Test Results Read* (Day/Time) *remember to return within 48-72 hours
	Health Office	Mon	Wed/Thurs/Fri
	Hinson Campus Center	9:00 a.m. – 10:00 a.m.	10:00 a.m. – 11:00 a.m.
	Lower Level	2:00 p.m. – 3:00 p.m.	3:00 p.m. − 4:00 p.m.
De Anza College		5:30 p.m. – 7:00 p.m.	5:30 p.m. – 7:00 p.m.
De Aliza Gollege	(408) 864-8732	Tues	
		10:00 a.m. – 11:00 a.m.	
		3:00 p.m. − 4:00 p.m.	
		5:30 p.m. – 7:00 p.m.	
	Health Office	Mon/Tues	Wed
	Campus Center	8:30 a.m. – 12:15 p.m.	8:30 a.m. – 12:15 p.m.
	Lower Level, Room 2126	2:00 p.m. – 3:00 p.m.	2:00 p.m. – 3:00 p.m.
	(next to the police station)		Fri
Foothill College			Walk-ins only**
	(650) 949-7243		
			**However, a reading must be
			done on Monday—within 72 hours!—or require a re-test.
			•

^{**}please call to confirm this time slot; availability fluctuates with staffing

NOTE: You must have your staff card (if received) and government picture ID (CDL, CID, or passport) to complete these services.

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT Office of Human Resources TB (TUBERCULOSIS) TEST FORM



Pursuant to Education Code Section §897408.6, all new employees (unless they have previously tested positive, followed by a negative chest x-ray) are required to have a PPD test and any follow up completed within sixty (60) days from the first day of service.

THE CAMPUS HEALTH SERVICES OFFICE OFFERS THE PPD TEST FREE OF CHARGE.

You may contact the Health Services office on either campus at:

DE ANZA: (408) 864-8732 **FOOTHILL:** (650) 949-7243

Those employees who test positive with a PPD must have a chest x-ray to rule out active TB. Employees will be referred by the Health Service Office to the appropriate medical facility.

Those employees who have tested positive previously are required to provide evidence of the positive PPD test followed by a negative chest x-ray. Such evidence shall be taken in person to the Campus Health Services Office.

PLEASE TAKE THIS FORM WITH YOU WHEN YOU HAVE YOUR TB TEST TAKEN.

To be completed by Employee:		
Last Name (Print) First Name Initial	Social Securit	ty Number
To be completed by Health Care Provider		
CERTIFICATION OF TUBERCULOSIS	S EXAMINATIO	N AND REPORT:
DATE GIVEN PPD TEST DATE READ	RESULTS	POSITIVE NEGATIVE
X-RAY DATE	_	
FOLLOW UP NO		
SURVEILLANCE DATE		
SIGNATURE OF HEALTH CARE PROVIDE	ER	DATE

Please return results/certificate to
Foothill-De Anza Community College District
Office of Human Resources
12345 El Monte Road
Los Altos Hills, CA 94022