FOOTHILL-DE ANZA
Community College District

Office of Human Resources and Equal Opportunity

2011 Open Enrollment Newsletter

to the Retirees, Survivors and COBRA Enrollees

March 31 – April 29, 2011

A Message from Christine Vo, Benefits Manager

Open Enrollment Summary for Plan Year 2011/2012

Open Enrollment is your annual opportunity to consider whether your health and welfare benefits meet your needs. It offers you an opportunity to review the benefit options offered by FHDA and **add** or **make changes** to your benefit package!

1) **OPEN ENROLLMENT** for Plan Year 2011/2012 is **March 31 to April 29.**

   If you or your dependents are not currently enrolled for health benefits, now is your opportunity! During open enrollment, you may

   a. Participate in the FHDA benefit programs
   b. Drop/waive your participation in the FHDA benefit programs
   c. Switch between Medical plans
   d. Add/drop your dependents

   Enrollment/changes will be effective **July 1, 2011 through June 31, 2012.** Open Enrollment is the only time to make changes unless you have a qualifying change in family status. The occurrence of a "qualifying event" (birth, marriage, adoption) will allow you to enroll dependents outside of Open Enrollment. See notice of special enrollment rights on the Annual Legal Notices page.

   The District will be continuing with our current medical plan offerings through UnitedHealthcare (UHC) and Kaiser. You have a choice between three medical plans (three medical plan options in CA):

   1. **Kaiser Foundation Health Plan** (HMO – *CA residents only)*
   2. **UnitedHealthcare CHOICE Health Plan** (Exclusive Provider Organization - **EPO**)
   3. **UnitedHealthcare CHOICE PLUS Health Plan** (Preferred Provider Organization - **PPO)**

IMPORTANT: If you make no election to change medical coverage, and/or add/delete dependent(s) your coverage will default automatically to your **current coverage** on July 2011.

2) WHAT'S NEW?

A. Self-Funded Medical Plans and Kaiser HMO

For the Plan Year 2011/2012, the following changes to the benefit design to comply with health reform:

- The Patient Protection and Affordable Care Act of 2010 requires that group health plans cover dependents on a parents plan until the dependent's 26th birthday through the date the child attains age twenty-six (26) without regard to student, marital, dependency, residency, or employment status. A dependent child is defined as your child or your spouse or domestic partner's child (natural, adopted, foster, stepchild, or a child place with you for adoption).
- Lifetime maximums have been removed
- Pre-existing condition limitations have been removed for members to age 19
- Preventive care is covered at 100% in-network on all plans.

B. Other changes to the benefit program, effective 07/01/2011, include:

UnitedHealthcare CHOICE (EPO) and CHOICE PLUS (PPO) Health Plans

- **Autism Coverage**
  The District is expanding coverage for autism under self-funded plans. The Plan offers diagnostic assessments and prescription medications, excluding applied behavioral analysis.

- **Hearing Aids Coverage**
  Hearing Aids benefit allowance is increasing from $1,000 to up $5,000 per calendar year. Subject to Annual Deductible and Coinsurance schedule is changing from 90% to 50%. Benefits are limited to a single purchase (including repair/replacement) every three years.

- **Therapeutic Treatments - Outpatient**
  The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology. Benefits will be subject to annual deductible and coinsurance.

3) HOW TO CHOOSE THE RIGHT HEALTH PLAN?

Please access **www.MyUHC.com** website and carefully look at the list of available providers in your area to determine which option is the best choice for you and your family. Before choosing the UnitedHealthcare **CHOICE** Health Plan (**EPO**) or UnitedHealthcare **CHOICE PLUS** Health Plan (**PPO**), please check UHC's website to be sure there are providers in your area that are part of those plans. You will receive greater savings and higher benefits when using an In-Network Provider.

Note: Members who reside *outside of the U.S.* territory, or in non-contracted service areas will default automatically to the **Out-of-Area (OOA)** Plan and premiums will be charged similarly to PPO option.

If you wish to participate in the Kaiser HMO, you must live within the CA Kaiser service area.

4) IF YOU ARE REQUESTING A CHANGE TO YOUR BENEFIT PLAN OR DEPENDENTS

You must participate in the annual open enrollment election between March 31-April 29, 2011 for **changes** effective July 1, 2011 if you would like to switch medical plans, change or cancel/waive your current benefit plan election or add/delete dependent(s).

The signed **"Request to Change Benefit Plan"** form must be completed in order to authorize your change in Benefit Plan selection or change in dependents covered in your plan. Please understand that **1)** once you authorize *a change in Plan*, you will not be allowed to change your plan until the next annual open enrollment for the plan year 12/13 (April 2012); and **2)** once you authorize a *change in dependent(s*), you will not be allowed to change your dependent coverage for the next plan year until the next annual open enrollment for the plan year 12/13 (April 2012), *unless you have a qualifying "change in family status"*.

The signed "Request to Change Benefit Plan" form also authorizes changes to your account and the monthly contributions required for your selection. **UnitedHealthcare Benefit Services** will withdraw your contributions accordingly for July 2011 contribution as your coverage begins July 1 for PY 2011/2012.

Note: If you add or delete a dependent, you will be required to provide documentation (marriage license, legal divorce decree signed by the judge, birth/death certificate, or legal adoption papers and copies of social security card) for each new dependent or change in status to Human Resources before the updates/changes can be completed. All required documentation must be submitted to the Human Resources Office by **5pm, Friday, April 29, 2011.** We cannot process benefit requests and your added dependent(s) will not be covered effective July 1, 2011 if we do not receive the necessary documents.

5) ELIGIBILITY FOR KAISER COVERAGE

In order to select the Kaiser Plan you **must** reside within the **Kaiser service area**. *If you reside outside of the Kaiser service area, you are not eligible to be insured under the Kaiser Program.* You may only select the Preferred Provider Organization (PPO) or the Exclusive Provider Organization (EPO) Medical Plan. If you reside within the greater Santa Cruz and Monterey counties or part of the Pope Valley and Bells Station communities (which lie within the zip codes 94567 and 95020), you are not in the Kaiser service area.

A. Senior Advantage Program:

If you are insured under the Kaiser Foundation Health Plan, ***you must notify Kaiser Permanente as soon as you become eligible for Medicare*** to sign up for

the Kaiser Senior Advantage Plan. The benefits are identical to the District's Kaiser Plan. This action is necessary to authorize Kaiser to initiate direct billing for all your medical claims with Medicare as the primary insurer. In return, the District receives a reduced premium for your medical coverage.

If You Fail to Notify Kaiser of Your Medicare Eligibility: Failure to sign up for the Kaiser Senior Advantage Plan immediately upon Medicare eligibility results disqualification from **all** District-paid benefits for you and the dependent(s).

B. If You Are Changing from Kaiser to a self-funded plan such as UnitedHealthcare CHOICE (EPO) or UnitedHealthcare CHOICE PLUS (PPO) Health Plan

If you are currently a Medicare recipient enrolled in the Kaiser Senior Advantage Program and wish to transfer your coverage to the District's UHC EPO or PPO Plan for the Plan Year 2011/2012, you must request a **Senior Advantage Disenrollment Form** from the Benefits Unit via email: MyBenefits@fhda.edu or call us at (650)-949-6224, to disallow Kaiser the right to bill Medicare effective July 1, 2011.

6) NEW BENEFITS CONTACT

Effective immediately, you may send **ALL** benefit inquiries to: **MyBenefits@fhda.edu,** a Benefit Team Member will reply to you within 24 hours from the time we received it. Benefits Unit may also be contacted at **650-949-6224.**

7) WHAT IF I HAVE QUESTIONS?

- Questions on self-funded Medical Plans such as EPO/PPO/OOA, verification of contracted medical, providers, Medicare coordination of benefits, please contact UnitedHealthcare Customer Care at toll-free **1-800-510-4846, Group # 708611.**

- Questions regarding KAISER Medical Plan, please contact Kaiser Customer Service at toll-free **1-800-464-4000, Group # 857.**

- To find the complete information on FHDA group benefit programs for current plan year, Annual and Privacy Notices, Claims Forms, Request to Change Benefit Plan Form, etc. at our website, **http://hr.fhda.edu/benefits.**

IMPORTANT DATES TO REMEMBER

Open Enrollment for Plan Year 2011/2012	March 31 – April 29, 2011
Benefits Workshop – Retirees Only	Friday, April 8, 1:00 pm - 2:15 pm (PST) De Anza College, Hinson Campus Center, Conference Rooms A & B
Benefits Workshop– Active Employees Only	Monday – Thursday, April 11-14 Please acces the benefits website: **http://hr.fhda.edu/benefits.** for details and locations
DEADLINE: Submit Enrollment Form	**Friday, April 29, 2011 – no later than 5:00 pm**

If you are unable to attend any of Benefits Workshop scheduled above, a PowerPoint Presentation of the Benefits Workshop will be available on the District benefits web page**:** **http://hr.fhda.edu/benefits** on Friday, April 15, 2011. Please feel free to contact us or UHC Customer Care at 1-800-510-4846, should you have any issues with accessing the Benefits Workshop Presentation.

REMINDER:

A. Where a qualified child is enrolled in a District health benefits plan:
(1) The child shall be covered as a dependent of only one employee or retiree; i.e., the employee or retiree and his/her spouse/domestic partner shall not both enroll the child as a dependent.

B. If You Are Medicare Eligible

Pursuant to the agreements with the bargaining units you are required to sign up for Medicare Part B, if you are eligible. Each retiree, and every eligible dependent, shall, upon obtaining eligibility for Medicare, notify the District of his/her eligibility. **It is your and your eligible dependent's sole responsibility to apply for, and satisfy the requirements of Medicare**. The District will reimburse retired employees and eligible dependents for the cost of optional Medicare to those who were hired before July 1, 1997, Part B on a quarterly basis (March, June, September, and December).

C. Where an employee, or retiree, and his/her spouse/domestic partner each choose the same plan, the District may administratively join the two individuals (and any qualifying dependents) on one plan, with either the employee or retiree identified as a dependent of the other. The District shall have the right to determine the conditions for, and ways of, administratively joining the plans in accordance with legal statutes.

D. Where a retiree is Medicare-eligible:

(1) Medicare shall be the PRIMARY payer for retirees in all cases.

(2) Retirees with Medicare who choose Kaiser shall participate in the Kaiser Senior Advantage program.

(3) The District Self-Funded Medical Plan shall be the SECONDARY or TERTIARY payer, depending on the benefit plan(s) specified in the retiree's Medicare Plan of Record.

(4) You may not enroll as "double-covered" Medicare member at any time; you must designate the District coverage as your Medicare Plan of Record.

(5) To receive plan benefits under all district-sponsored Medicare plans, you must use a provider who participates in Medicare. If your doctor does not take Medicare patients or will only render services under a "private contract" directly with you, neither Medicare nor your district-sponsored medical plan will cover the services. If

your doctor takes non-Medicare patients but not Medicare patients, you may need to select a new doctor when you become eligible for Medicare.

(6) Each retiree shall continue to be entitled to his/her post-retirement paid benefits for retired employees in accordance with the contractual agreements with the various bargaining units.

THE DEADLINE FOR OPEN ENROLLMENT FOR PLAN YEAR 2011-2012 is Friday, April 29, 2011 – 5:00 P.M.

IMPORTANT: This memorandum does not provide all of the contractual provisions, limitations or exclusions included in our policies and should be considered only as a summary of our current benefits. A complete description of each benefit can be found in the Benefit Program Booklets provided by the insurance carriers. If any discrepancies exist between this summary and the contract, the contract shall prevail.

IMPORTANT NOTICE TO RETIREES

A. RETIREE CONTRIBUTIONS

The District will continue to fund the majority of the premium costs for all of our health plans; your contribution is a portion of the total cost.

For Plan Year 2011/2012, the monthly retiree contributions are **required** to be deducted from either checking or saving account via ACH process or electronic fund transfers.

For Plan Year beginning July 1, 2011 through June 30, 2012, your monthly contributions will remain the same. Your monthly contributions are as follows:

Monthly Retiree Contributions over 12 months period: July 2011 - June 2012

Employee/Retiree Monthly Contribution	KAISER	UHC EPO	UHC PPO/OOA
Retiree Only	$48.00	$48.00	$120.00
Retiree + One Dependent*	$96.00	$96.00	$240.00
Retiree + Two or More Dependents*	$144.00	$144.00	$360.00
Note: Please be advised that the employee contribution rates include $1/mo. for Vision and $4/mo. for dental, and the remainder belong to the medical care.			

*For domestic partners and their children that do not qualify as dependents under Section 152 of the Internal Revenue Code, premiums associated with domestic partner coverage will be paid by the employee with after-tax dollars and the fair market value of any Foothill-De Anza Community College District's contributions made on behalf of your domestic partner will be imputed as income to the employees.

B. RETIREE BILLING STANDARDS

- Payments to the plan **must** be made by direct withdrawal from the retiree's checking or savings account via **ACH (Automated Clearing House) process**, also known as Electronic Fund Transfer (EFT) Process.

- **Grace Periods** – Premium are usually generated by the 10th of the preceding month, giving the retiree 20 days for timely payment by the first of the coverage month. The additional 30 days grace period creates a combined period of 50 days for the retiree to make payment.

- **Premium Withdrawal -** Premium is due by the 1st of each month, e.g. January premium is due January 1st. UnitedHealthcare (UHC) will debit your account on

that day, or the first banking day of the month if the 1st falls on a weekend or holiday.

Automatic withdrawals will continue as the premiums come due until you cancel this agreement by submitting the request in writing to *UnitedHealthcare Benefit Services, P. O. Box 221709, Louisville, KY 40252.*

- **Insufficient Fund –** If the automatic withdrawal is rejected by your bank due to insufficient funds or other circumstances, UnitedHealthcare will attempt to resubmit the automatic withdrawal one more time within the grace period of 30 days. Any automatic withdrawal not honored after the grace period expires will result in cancellation of your retiree medical plan.
- **Notice of Insufficient Fund –** If an adequate withdrawal cannot be made at or near the 1st of each month, UHC will send out a notice of insufficient funds reminding you of the grace period. You will have 30 days from the date of the notice is printed to fund your account.

  If a second notice of insufficient funds is sent out within the same plan/calendar year, the grace period will not apply, and your coverage will be terminated immediately.
- **Notification of Coverage Termination** – If payment is not received by the end of the 30-day grace period, coverage is terminated and the administrator will send out a termination notice.

  Reinstatements – If your retiree coverage is terminated due to insufficient fund balances, you will be permitted to re-enroll in the plan 12 months after the date of termination.

  Once a lapse occurs, a lapsed retiree to wait for 12 months before reinstatement. For example, if you failed to pay for the October premium by October 31st due to insufficient fund, your policy will be cancelled retroactively to September 30th. You will be given a special open enrollment for reinstatement of coverage after a full 12-month waiting period. During this period of time, the District will also stop reimburse you for the Medicare Part B premium if applicable.

IMPORTANT: Reinstatement will not be available to any retiree following a second termination from the plan. Thereafter, you will be permanently removed from all district-paid benefits as a retiree.

IMPORTANT: This memorandum does not provide all of the contractual provisions, limitations or exclusions included in our policies and should be considered only as a summary of our current benefits. A complete description of each benefit can be found in the Benefit Program Booklets provided by the insurance carriers. If any discrepancies exist between this summary and the contract, the contract shall prevail.