FOOTHILL-DE ANZA
Community College District

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

TO: All Retirees, Surviving Spouses and COBRA Enrollees
FROM: Christine Vo, Benefits Manager
DATE: April 3, 2009
RE: **Annual Benefits Open Enrollment (April 6-30, 2009)**

1) BENEFITS ELECTION FOR JULY 2009– JUNE 2010

OPEN ENROLLMENT for Plan Year 2009/2010 is **April 6 to April 30.** During this time you have the opportunity to elect to change from one medical plan to another or to add, delete or change dependents. The District offers three options:

1) **Kaiser Foundation Health Plan (HMO)**,
2) the **Exclusive Provider Organization (EPO) Medical Plan***, and
3) the **Preferred Provider Organization (PPO) Medical Plan***

***Please see #2 below regarding the name change for the District's Self-Funded Plans.

The changes are effective **July 1, 2009** and will be applicable for a **twelve (12) month period ending June 30, 2010.**

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 2009.

2) DISTRICT SELF-FUNDED MEDICAL PLANS

A. Name Change:
- The District Network Only Medical Plan (PPO) shall be known as the **Exclusive Provider Organization (EPO) Medical Plan.**
- The District Combined Coverage Medical Plan (PPO+) shall be known as the **Preferred Provider Organization (PPO) Medical Plan.**

B. Members Living Outside the U.S. or in Non-Contracted Service Areas

To insure under the "Exclusive Provider Organization (EPO) Medical Plan", (previously known as the PPO Network Only Medical Plan), you must have access to contracted UnitedHealthcare providers and facilities within a 30 miles radius from your home residence. Otherwise, you must select the PPO Plan.

Members who reside outside of the U.S. territory, or in non-contracted service areas, will default automatically to the PPO Plan and premiums will be billed accordingly.

C. 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, Part B on a quarterly basis (March, June, September, and December).

D. If You Are Requesting a Change to Your Benefit Plan or Dependents

The signed **"Request to Change Benefit Plan"** form must be completed in order to authorize your change in Benefit Plan selection or change in dependants 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 10/11 (April 2010); 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 10/11 (April 2010), *unless you have a qualifying "change in family status"*.

If you add or delete a dependent, you must 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 **April 30, 2009.** We cannot process benefit requests and your added dependent(s) will not be covered effective July 1, 2009 if we do not receive the necessary documents.

The signed "Request to Change Benefit Plan" form also authorizes changes to your account and the monthly billing, if required, for your selection. **UnitedHealthcare Benefits Services** will bill retirees with one or more dependents, who select the PPO Plan accordingly.

E. Locating Forms

You may locate a "Request to Change Benefit Plan" form at http://hr.fhda.edu/benefits/ or use the enclosed form.

F. Notification from Secova to Confirm Your Selection – May 15th

You will receive an official benefits confirmation statement from Secova, on-line benefits carrier, confirming your plan selection, and notifying you of the requirement to submit documentation for verification of dependents, if applicable, May 15th. For ALL plans, it is your responsibility to notify the District of any changes regarding eligibility. Failure to act in a timely manner may disqualify you from receiving District-paid benefits, and/or deny your benefits claim(s). You are required to notify the District's Human Resources Office in writing within **31 days** whenever there is a change in dependent status, and within **10 days** if there is a change in address. Your prompt cooperation in this matter is greatly appreciated.

G. Billing Service if You Have Dependents Insured Under the PPO Plan (formerly known as PPO+)**:**

If you elect the PPO Medical Plan and have dependant(s) covered under this Plan, you are required to make a contribution for your dependent coverage.

- If you have one dependent, the monthly contribution is **$142.08.**
- If you have two or more dependents, the monthly contribution is **$266.38.**

UnitedHealthcare Benefits Services will bill you directly for these costs beginning July 1, 2009. Surviving Spouses and COBRA enrollees will continue to be billed by the District.

For More Information:
For information regarding billing or automated bank transfer via Automated Clearing House (ACH), a nationwide electronic funds transfer (EFT) system, please contact:

UnitedHealthcare
P. O. Box 221709
Louisville, KY 40252
Customer Service Phone: (866) 747-0048

IMPORTANT: If you have already authorized ACH service from the prior year, your July 2009 premium will be deducted via EFT with **UnitedHealthcare Benefit** Services, based on the current financial information on record. Thus, you do not need to do anything.

*If you will be **newly** enrolled* in the PPO Plan (effective July 1, 2009), you must pay the July 2009 premium invoice with a **regular check**. Thereafter, the ACH service will be available. An ACH form will be provided along with your initial billing statement, for your convenience.

To Make a Premium Payment:
Please ensure that the check or money order is signed, properly dated, and references your UHC account number on the lower left corner of check. **Make the check payable to UnitedHealthcare,** and submit the payment to:

UnitedHeatlhcare Benefit Services
P. O. Box 713082
Cincinnati, OH 45271-3082

H. Reviewing the Status of Your Account
You may review your account status by accessing: **www.uhcservices.com**. You may also obtain information, print Premium Statements and communicate with **UnitedHealthcare Benefit Services**. You will need your Social Security Number and birth date for your initial log-in. Then, you should receive a password from UnitedHealthcare Benefit Services within two days. This password should be retained for future log-in purposes.

3) KAISER MEDICAL PLAN:

A. 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 (PPO) 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.

B. 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* and sign up for the Kaiser Senior Advantage Plan. *This Plan is identical to the District Kaiser Plan*.

This action is necessary to authorize Kaiser to do 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***
> If you fail to notify Kaiser of your Medicare eligibility, or fail to sign up for the Kaiser Senior Advantage Plan, the District will immediately disqualify you from **all** District-paid benefits.

C. If You Are Changing from Kaiser to a District EPO or PPO Plan

If you are currently a Medicare recipient enrolled in the Kaiser Senior Advantage Program and wish to transfer your coverage to the District EPO or PPO Plan for the Plan Year 2009/2010, you must request a **Senior Advantage Disenrollment Form** from Christine Vo, Benefits Manager, to disallow Kaiser the right to bill Medicare effective July 1, 2009.

4) EPO/PPO PRESCRIPTION DRUG PLAN – Elimination of Mandatory Mail Order

Effective July 1, 2009, the District self-funded medical plan participants are no longer *required* to use Medco Prescription Mail Order after the third refill at a local retail pharmacy. Mail order prescription refill service shall continue to be available, but is no longer mandatory.

5) EPO/PPO MEDICAL PLAN – Cap on Private Duty Nursing

Private Duty Nursing will have an annual limit of $25,000.

6) MEDICAL/Rx/DENTAL/VISION/EAP PLANS – *Elimination of Dual Coverage*:

In cases where a District employee or retiree has a spouse/domestic partner who is also an employee or retiree of the District, each shall be covered individually as an employee or retiree and shall have the right to choose his/her own plan, but neither shall be covered as a dependent on his/her spouse's/domestic partner's plan or any other District plan, except as administratively joined as described in "A" below. Qualified dependents shall be covered by one employee or retiree only as described in "B" below.

Implementation provisions:

A) 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.

B) 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.

(2) The child shall be enrolled as a dependent of the employee or retiree who, in accordance with IRS regulations is eligible to claim the child as an IRS-qualified child tax dependent on his/her federal income tax return.

C) 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) 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.

IMPORTANT: This is a summary of the most frequently used benefit provisions. Please refer to the Evidence of Coverage or the Summary Plan Description for complete details of benefit limitations, exclusions and general program parameters.

THE DEADLINE FOR OPEN ENROLLMENT FOR PLAN YEAR 2009-2010 is Thursday, April 30, 2009 – 5:00 P.M.