



SAN MATEO COUNTY
COMMUNITY COLLEGE DISTRICT

2011 Employee Benefits



Table of Contents

About this Guide.....	1	Flexible Spending Accounts	11
What’s New for 2011	2	Life and AD&D Insurance	12
Eligibility for Benefits	3	Supplemental Life	13
Making Changes to Your Benefits.....	3	Disability.....	14
Medical Plan Choices	4	Long Term Care Insurance — Voluntary	14
Medical Choices — HMO Plans	6	Employee Assistance Program	15
Medical Choices — PPO Plans	7	Benefits Contacts	17
Wellness Resources	8	Glossary	18
Dental Plans	9	Your Rights	20
Vision Plan	10	Medicare D Prescription Drug Notice	24



About This Guide

We understand that choosing your benefits is an important decision for you and your family. Everyone’s needs are unique. We offer a variety of benefits and options so you can choose what works best for you and your family. A number of these benefits are provided at no cost to you. We created this guide to help you make informed decisions. It is not a complete detailed description, nor is it a contract of employment or a guarantee of benefits. More detailed information for each benefit is contained in the relevant insurance policy’s Summary Plan Description (SPD).

Great care has been taken to ensure that this guide is accurate. However, oversights can occur or condensed summaries can be misinterpreted. If there is a difference between this overview and the SPD or official plan documents governing the plan, the plan documents will be followed. The district reserves the right to amend or terminate the program in whole or in part at any time.

New for 2011

As you review this guide, you will learn about a number of important changes in the benefits provided to you and your dependents.

Because this document modifies information contained in SMCCCD's Summary Plan Description (SPD) and Plan Document provided to you earlier, please keep it with your benefits plan documents.

A number of changes this year are dictated by the healthcare reform legislation which became law in March 2010.



Benefit Changes	Applies to the Following Benefits
Over-the-counter drugs and medications will not be reimbursed <i>unless</i> they have been prescribed by a doctor. The only exception is insulin.	Health Care Flexible Spending Account
The lifetime limit on the dollar value of health benefits no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan during Open Enrollment for a June 1, 2011 effective date.	Anthem
Our medical plans contain no pre-existing condition limitations or exclusions for children under age 19.	Kaiser, Blue Shield, Anthem
Dependent children are eligible until age 26, regardless of student status. As a result, dependent children whose coverage ended, or who were not eligible for coverage, because the coverage was limited to full time students and/or because coverage was limited and ended before attainment of age 26, are now eligible to enroll in certain benefits, as described in the "Eligibility" section on the next page. You may request enrollment for these children during Open Enrollment for January 1, 2011 effective date.	Kaiser, Blue Shield, Anthem, VSP, Delta Dental, DeltaCare PMI

Eligibility for Benefits

You are eligible to enroll in benefits if you are a Regular faculty employee working at 60% or more of full-time or a Classified employee working at 50% or more of full-time. The following family members may be enrolled in the medical, dental and vision programs:

- Your legal spouse or qualified domestic partner
- For medical, dental and vision benefits, children to age 26
- Your dependent child who is incapable of self support because of a mental or physical disability

For the purpose of our benefit plans, your children include:

- Natural and adopted children
- Children of your qualified domestic partner
- Stepchildren who you support and who live with you in a parent-child relationship
- Any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order

If you or a covered family member no longer meet these eligibility requirements or if your employment ceases, coverage ends on the last day of the month. You are responsible for informing Human Resources within 30 days if any of your dependents become ineligible for benefits.



Making Changes to Your Benefits

During Open Enrollment you can change your benefit choices. Open Enrollment begins September 13, 2010 and ends October 8, 2010 and changes are effective on January 1. Your decisions remain in effect for twelve months unless you have a qualifying life event as defined by the IRS:

- The addition of a dependent through birth, adoption or marriage
- The loss of a dependent through divorce or death, or if your child reaches the maximum age limit for coverage
- A change in the employment status of you or your spouse (e.g., from full-time to part-time or vice versa)
- A substantial change in your benefits coverage or a spouse's coverage
- The addition or separation of a qualified domestic partner
- Change in eligibility for Medicaid or Children's Health Insurance Program (CHIP) subsidy

Any benefit changes must be consistent with the type of event you experience. If you add a dependent, you can add them to your benefits but you cannot drop another dependent from benefits. For example, if you have a baby, you can add the baby to your medical plan but you could not drop a spouse from the plan.

If you experience a family status change and want to change your benefits, you **MUST** contact Human Resources within 30 days of the change.

If you decline enrollment for yourself or your dependent (including your spouse) because of other health insurance coverage and that coverage ends, you may be able to enroll yourself or your dependents in this plan outside of Open Enrollment. In order to exercise this option, you must request enrollment during the first 30 days after your other coverage ends or within 60 days if you experience a loss of eligibility for the Children's Health Insurance Program (CHIP).

Medical Plan Choices

SMCCCD offers regular employees a choice of six medical plans, each with different levels of coverage and cost. SMCCCD recognizes that selecting a medical plan to cover you and your family is an important decision. In the event of a serious illness or injury, your medical plan can help you regain optimal health; it can also help you identify potential health issues before they become serious health problems.

Questions that may be helpful in choosing the right medical plan for you and your family include:

- Does this plan offer the benefits and services most important to me?
- Does my doctor participate in this plan's network? If not, is it worth it to me to pay more out of pocket if I choose to stay with my doctor?
- How does the plan work?
- How much will it cost?

Before selecting a medical plan, you should contact the plan to make sure they currently cover your ZIP Code and that their provider network is accepting new patients in your area. You may also use **Health Plan Search by ZIP Code**, available at www.calpers.ca.gov, to determine which plans are available.

Medical Plan Choices

2011 Monthly Medical Premium*		AFT, Academic Supervisory, and Administrators		AFSCME, CSEA, Classified Professional/Supervisory and Confidential	
<i>Plan Name</i>	<i>Total Premium</i>	<i>Portion Paid by District</i>	<i>Your Cost</i>	<i>Portion Paid by District</i>	<i>Your Cost</i>
Blue Shield Access+ HMO					
Employee	\$675.51	\$604.00	\$71.51	\$604.00	\$71.51
Employee + 1 Dependent	\$1,351.02	\$901.34	\$449.68	\$976.60	\$374.42
Employee + 2 or More Dependents	\$1,756.33	\$1,183.74	\$572.59	\$1,281.58	\$474.75
Blue Shield NetValue HMO (Please contact Blue Shield to make sure you qualify: 800-334-5847)					
Employee	\$581.24	\$581.24	\$0.00	\$581.24	\$0.00
Employee + 1 Dependent	\$1,162.48	\$901.34	\$261.14	\$976.60	\$185.88
Employee + 2 or More Dependents	\$1,511.22	\$1,183.74	\$327.48	\$1,281.58	\$229.64
Kaiser Permanente HMO					
Employee	\$568.99	\$568.99	\$0.00	\$568.99	\$0.00
Employee + 1 Dependent	\$1,137.98	\$901.34	\$236.64	\$976.60	\$161.38
Employee + 2 or More Dependents	\$1,479.37	\$1,183.74	\$295.63	\$1,281.58	\$197.79
Anthem Blue Cross PPO (PERS Choice) 80/20 Plan					
Employee	\$563.40	\$563.40	\$0.00	\$563.40	\$0.00
Employee + 1 Dependent	\$1,126.80	\$901.34	\$225.46	\$976.60	\$150.20
Employee + 2 or More Dependents	\$1,464.84	\$1,183.74	\$281.10	\$1,281.58	\$183.26
Anthem Blue Cross PPO (PERS Select) 80/20 Plan Reduced Network					
Employee	\$492.68	\$492.68	\$0.00	\$492.68	\$0.00
Employee + 1 Dependent	\$985.36	\$901.34	\$84.02	\$976.60	\$8.76
Employee + 2 or More Dependents	\$1,280.97	\$1,183.74	\$97.23	\$1,280.97	\$0.00
Anthem Blue Cross PPO (PERS CARE)					
Employee	\$893.95	\$604.00	\$289.95	\$604.00	\$289.95
Employee + 1 Dependent	\$1,787.90	\$901.34	\$886.56	\$976.60	\$811.30
Employee + 2 or More Dependents	\$2,324.27	\$1,183.74	\$1,140.53	\$1,281.58	\$1,042.69

*There are certain tax consequences or liabilities that may apply.

Medical Choices—HMO Plans

PLAN FEATURES	Blue Shield HMO* Access+ and NetValue	Kaiser*
	With this plan, you must select a Primary Care Physician (PCP) and medical group for you and each of your dependents. Each family member can have a different PCP. All care, except emergency services, must be coordinated through your PCP in order to receive the benefit. You may change PCPs each month by calling Member Services.	You must receive all services from a Kaiser physician at a Kaiser facility, except in cases of medical emergency.
GENERAL PLAN PROVISIONS		
Maximum lifetime benefit	Unlimited	Unlimited
Deductible—individual / family	None	None
OUTPATIENT SERVICES		
Office visits	\$15	\$15
Annual check-ups	No charge	No charge
Well baby care	No charge	No charge
Lab and x-ray	No charge	No charge
HOSPITAL SERVICES		
Emergency room <i>(copay waived if admitted)</i>	\$50	\$50
Ambulance	No charge	No charge
Inpatient hospital	No charge	No charge
PRESCRIPTION DRUGS (generic / formulary / non-formulary)		
Retail	\$5 / \$15 / \$45 - 30 days	\$5 / \$15 - 100 days
Mail order	\$10 / \$25 / \$75 - 90 days	\$10 / \$30 - 100 days
ADDITIONAL SERVICES		
Chiropractic services	Not covered	As of January 1, chiropractic services will no longer be covered
Infertility	50% of covered charges	50% of covered charges
Skilled nursing facility care <i>(100 days per calendar year)</i>	No charge	No charge
Durable medical equipment	No charge	No charge

***Your Right to Designate an HMO Primary Care Provider**

You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the HMO will designate one for you. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization to obtain access to OB-GYN specialists in the network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Medical Choices—PPO Plans

PLAN DESIGN	Anthem—PERS Select & PERS Choice		Anthem—PERS CARE	
	<p>With these plans, you have the flexibility to see any provider you wish. If you choose an in-network provider or hospital, you will pay less. Before the insurance company begins paying for benefits, you will need to pay the deductible. The only exceptions are services for which you pay a copay.</p> <p>The PERS Select and PERS Choice plans offer identical benefits but the PERS Select network is much smaller. The PERS CARE plan offers the richest level benefits but you will have to pay more each month from your paycheck.</p>			
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
GENERAL PLAN PROVISIONS				
Maximum lifetime benefit	None		None	
Coinsurance (<i>amount you pay</i>)	20%	40%	10%	40%
Deductible—individual / family	\$500 / \$1,000		\$500 / \$1,000	
Out-of-pocket maximum (individual / family)	\$3,000 / \$6,000	None	\$2,000 / \$4,000	None
OUTPATIENT SERVICES				
Physician services	\$20	40%	\$20	40%
Annual check-up	No charge	40%	No charge	40%
Lab and x-ray	20%	40%	10%	40%
HOSPITAL SERVICES				
Emergency room (<i>copay waived if admitted</i>)	20% after \$50 deductible		10% after \$50 deductible	
Ambulance	20%	20%	20%	20%
Inpatient hospital	20%	40%	10%	40%
PRESCRIPTION DRUGS (generic / formulary / non-formulary)				
Retail	\$5 / \$15 / \$45 - 30 days		\$5 / \$15 / \$45 - 34 days	
Retail after 2nd refill	\$10 / \$25 / \$75 - 30 days		\$10 / \$25 / \$75 - 34 days	
Mail order	\$10 / \$25 / \$75 - 90 days		\$10 / \$25 / \$75 - 90 days	
ADDITIONAL SERVICES				
Chiropractic services / acupuncture	20%	40%	10%	40%
Skilled nursing facility care (<i>pre-certification required</i>)	20% - first 10 days 30% - next 90 days	40% - first 100 days	10% - first 10 days 20% - next 170 days	40% - first 10 days 40% - next 170 days
Durable medical equipment (<i>pre-certification required; \$3,000 limit per year</i>)	20%	40%	10%	40%

Wellness Resources

Staying healthy is all about making wise health care decisions and taking a proactive role in improving and maintaining your physical and emotional health. Kaiser, Anthem and Blue Shield offer many resources that will help you make the most of your benefits. Programs vary by carrier. To find out more information, visit their websites: www.kp.org (Kaiser), www.anthem.com/CA (Anthem Blue Cross) and www.blueshieldca.com (Blue Shield of California).

When you visit your insurance company's website, you can learn about different health conditions, take online classes to help you achieve nutrition or fitness goals, evaluate the state of your health through a Health Assessment Tool and get discounts on the goods and services you need to stay looking and feeling your best.

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My health manager
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- Refill prescriptions
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REFILL A PRESCRIPTION

CHECK CLAIM STATUS

SHOP FOR:

Health
 Medicare
 Dental
 Vision

FOR INFORMATION FOR:

Providers
 Employers
 Agents/Brokers
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TriWest Healthcare Alliance Awarded 5 Year, \$10 Billion Healthcare Contract

I'm a provider
 Get information about your patient's coverage

I'm a producer
 Find plans that serve your clients' needs

I'm an employer
 Manage your employees' health coverage

i need to find a provider
 Find a doctor, dentist, hospital, urgent care center, or other healthcare provider in our network.

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 Shop for your own health coverage

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Dental Plans

SMCCCD offers regular employees two comprehensive dental plans to choose from. These plans are designed to provide you with preventive care as well as coverage to assist with more serious dental issues, if needed.

Delta Dental Plan

When you enroll in the Delta Dental Plan, you may receive dental care services from any dentist. When you choose to receive care from a Delta Dental Provider, you will be charged the patient share of the Delta Dental approved fees (see chart below).

If you choose to receive care from a non-Delta dentist you may be responsible for paying any charges over Delta Dental's approved fees. Additionally you may be responsible for the submission of claim forms and will be required to pay the full amount for treatment at the time services are received.

For more detailed information or to locate a participating dentist, call Delta Dental toll-free at (800) 765-6003 or visit their website at www.deltadentalca.org.

PLAN DESIGN	DeltaDental PPO	
	IN-NETWORK	OUT-OF-NETWORK
ANNUAL BENEFIT MAXIMUM		
Annual dental maximum	\$2,200 per person*	\$2,000 per person*
ANNUAL DEDUCTIBLE		
Individual / family	None	
COVERED SERVICES		
Preventive and Diagnostic Includes: exams, teeth cleaning and x-rays. Additional cleanings are covered for pregnant women or individuals with diabetes.	Covered at 70% of contracted fees**	
Basic Includes: fillings, extractions, endodontics, periodontics and oral surgery	Covered at 70% of contracted fees**	
Jackets, Crown Restoration	Covered at 70% of contracted fees**	
Prosthodontic	Covered at 50% of contracted fees	
Dental Accidents Benefit	Covered at 100% with a separate maximum of \$1,000 per person per calendar year	

* Calendar year maximums cannot be combined for In Network and Out of Network benefits.

**The 70% benefit level applies during the first year you participate in the Delta Dental Plan. Your coverage will increase by 10% each year (to a maximum of 100%) provided you visit a dentist at least once a year.

DeltaCare (PMI) Plan

When you enroll in the DeltaCare (PMI) Plan, you must receive all dental care services from a dentist who participates in the DeltaCare (PMI) network (please note that the network is very limited).

Most services will be covered at 100% with no out-of-pocket costs with the exception of some major services. This plan includes orthodontic care for children only; services must be provided by a DeltaCare PMI orthodontist.

For more detailed information or to locate a participating dentist, call DeltaCare (PMI) toll-free at (800) 422-4234 or visit their website at www.deltadentalca.org/pmi.

Vision Plan

SMCCCD provides regular employees with vision coverage through Vision Service Plan (VSP). Please see the chart below for benefits when visiting a VSP network provider.

Note: you will not receive an ID card from VSP automatically. Your provider can verify your eligibility without a card, but if you prefer to have an ID card, please visit www.vsp.com.

Through VSP, you also have access to the following discounted services:

- Laser vision correction discounts
- Up to 20% savings on lens coatings such as scratch resistant lenses, anti-reflective coatings and progressives
- 30% discount on additional prescription glasses and sunglasses if ordered on the same day
- Additional discounts on the fitting and evaluation on contact lenses



As a VSP member, you can access out of network providers but you will be required to pay the provider in full at the time of service and will need to submit a claim form to VSP. With an out of network provider, you will receive lower benefits and typically pay more out of pocket.

PLAN DESIGN	IN-NETWORK	OUT-OF-NETWORK
COPAY FOR EYE EXAM (one exam every 12 months)	\$10	\$10
EYEGLASS LENSES (one pair every 12 months)		
Single vision	Paid in full	\$45 maximum benefit
Lined bifocal	Paid in full	\$65 maximum benefit
Lined trifocal	Paid in full	\$85 maximum benefit
EYEGLASS FRAMES (one pair every 12 months)	Covered up to \$130 plus 20% off any out-of-pocket costs	Covered up to \$50
<i>OR</i>		
CONTACT LENSES (one order every 12 months)		
Visually Necessary	Paid in full	\$210 maximum benefit
Elective	Covered up to \$105 in lieu of frames and lenses	Covered up to \$105 in lieu of frames and lenses

Primary Eyecare Benefit

If you or members of your family experience a medical eye condition that requires diagnosis and treatment, visit your VSP network doctor. Examples of such conditions include: cataracts, styes, pink-eye and macular degeneration. Rather than an unnecessary trip to the emergency room, you can receive prompt, comforting, familiar treatment from your VSP network doctor who already knows your eyecare and medical history. **A \$5 copay is required for these visits.**

Flexible Spending Accounts

Flexible Spending Accounts allow you to pay for goods and services you already use with money deducted from your paycheck before it is taxed. This can reduce your eligible health care and dependent care expenses by as much as 30%. These plans are administered by Payflex.

The FSA plan year is from January 1 to December 31. Plan carefully when determining how much to contribute. The IRS has imposed a “use it or lose it” rule. You must incur FSA-eligible expenses before December 31, 2011. However, you have until March 31, 2012 to submit claims for reimbursement. Any amounts remaining in your health care or dependent care accounts after this time will be forfeited, as required by law. Note: expenses incurred by domestic partners and their children do not qualify as eligible expenses per Internal Revenue Code 125.

Health Care FSA—up to \$5,000 annually

This allows you to pay for qualifying out-of-pocket health care expenses for you and your dependents. The amount you choose to contribute will be deducted from your pay in equal installments throughout the year. You cannot change this amount unless you have a qualifying life event (see *Eligibility for Benefits* on page 3).

Dependent Care FSA—up to \$5,000 annually

Eligible expenses are those you must pay for dependent daycare so that you can work. If you are married, your spouse must also work full time, be actively seeking employment or attending school full time. If your spouse also contributes to a Dependent Care FSA, your total contributions as a couple cannot exceed \$5,000. While you may use these funds to pay a relative, that individual must be over the age of 13 and cannot be considered one of your tax dependents.



Sample FSA-Eligible Expenses. As of January 1, 2011, over-the-counter (OTC) medicines or drugs, except for insulin, *will* require a prescription in order to be eligible for reimbursement. Please plan accordingly when determining your Health Care FSA contributions and check with Human Resources for additional information.

Health Care Expenses

Acupuncture
Alcoholism treatment
Chiropractic treatments
Deductibles and copays
Dental fees
Eye exams and eye surgery
Hearing exams and hearing aids
Hospital bills
Insulin
Laboratory fees
LASIK surgery
Obstetrics and fertility
Orthodontia expenses
Psychiatrist and psychologist fees
Prescription drugs
Smoking cessation programs (if prescribed by your doctor)
X-rays and MRI

OTC Items

Prescription Required

Allergy medications
Acne medications
Antifungal treatments
Anti-inflammatory medication
Anti-itch medications
Aspirin
Asthma medications
Cold sore medications
Cough, cold and flu medications
Diaper rash ointment
Digestion/gas aids
First aid cream
Hydrogen peroxide
Laxatives
Pain relief (e.g., aspirin)
Sinus medications
Sleeping aids

OTC Items

No Prescription Required

Baby electrolytes
Blood pressure monitor
Contact lens solution
Contraceptive devices
Diabetic supplies, including insulin and glucose meters
Eye care products (e.g., saline)
First aid supplies (e.g., band-aids)
Hearing aid batteries
Hot and cold packs
Medicated bandages
Motion sickness tablets
Pregnancy tests
Reading glasses
Supports/braces (e.g., wrist)
Thermometers

Sample Dependent Care Expenses

After school care
Au pair
Baby-sitter
Care for children under age 13
Elder care
Extended day programs
Nanny fees
Nursery school
Preschool for under 5 years old
Sick-child center
Summer day camp
Care for an adult dependent in an adult day care center
Expenses for day care, summer camps, etc. cannot be submitted until after services have been received.

Life and AD&D Insurance

Basic Life and Accidental Death and Dismemberment (AD&D) coverage is provided at no cost to you. Life insurance provides some financial security to your dependents in the event of your death. If you have a qualifying accident which results in the loss of limb(s) or eyesight, you will receive a percentage of the AD&D amount. The Hartford insures these benefits.



Basic Life Insurance

Your benefit	If you are a certificated or classified employee and your death occurs while you are covered under the plan, your beneficiary will receive a benefit amount equal to your annual salary up to a maximum of \$100,000. If you are an administrator or trustee and your death occurs while you are covered under the plan, your beneficiary will receive a benefit amount equal to twice your annual salary up to a maximum of \$500,000.
Benefits for dependents	SMCCCD provides the following life insurance coverage for your dependents: Spouse: \$1,500 Child(ren) 6 months through age 22: \$1,500 Child(ren) birth to 6 months: \$100
Reductions to the benefits if you are working	At age 65: coverage is reduced by 35% At age 70: coverage is reduced by 50%
Coverage during disability	If you become totally disabled prior to age 69, only basic life insurance will continue and premium will be waived after you have been totally disabled for 6 months. Coverage will continue without premium payment until you recover or you attain Normal Retirement Age, whichever occurs first.
Accelerated benefit	If you are terminally ill, you can receive up to 80% of your lifetime benefit to a maximum of \$500,000 in a lump sum as long as your life expectancy is less than 12 months. Your death benefit will be reduced by this accelerated payment.
Portability	You may be able to continue your current coverage at group rates up to a maximum \$250,000 of group life and AD&D insurance combined. Contact the insurance company for details and rates.
Conversion	You may convert the Life insurance policy to an individual policy upon termination of your employer provided coverage. You have 31 days from termination to convert your policy. Contact the insurance company for details and rates.
Beneficiary designation	It is your responsibility to ensure that your beneficiary information is correct. If you experience a life event change, like marriage or divorce, contact Human Resources to update your beneficiary.

IRS regulations allow employers to provide up to \$50,000 of life insurance to employees on a tax-free basis. The premium paid on behalf of employees for coverage amounts in excess of \$50,000 will be added to the employee's gross income for tax purposes. This is referred to as "imputed income".

Accidental Death & Dismemberment Insurance

Your benefit	If you die as the result of an accident, an additional benefit will be paid to your beneficiary. Partial benefits are payable if you lose your eyesight or a limb as the result of an accident.
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Supplemental Life Insurance—Voluntary Benefit

While the basic life insurance benefit was designed to provide a foundation for you and your dependents, we recognize the potential need to increase your family's protection. Through our benefit program, you have access to voluntary supplemental term life insurance. This program allows you to purchase additional amounts of insurance at favorable group rates with certain amounts of coverage guaranteed. Premiums are paid through after-tax payroll deductions. These benefits are insured by The Hartford.

To apply for additional life insurance, please contact Human Resources for the necessary paperwork.



Supplemental Life Insurance

Your benefit	Eligible employees may purchase supplemental life insurance coverage in increments of \$10,000 to a maximum of \$500,000 (not to exceed three times your annual salary). Evidence of Good Health is required by The Hartford. New employees who enroll within 31 days of employment will need to provide Evidence of Good Health for any amount over \$100,000.
Spouse/domestic partner benefit	You may purchase additional coverage for your spouse /domestic partner in increments of \$5,000 up to a maximum of \$250,000 (not to exceed 50% of your supplemental life insurance coverage). Please note you cannot purchase this coverage for your spouse if your spouse is covered as an employee under this plan. Evidence of Good Health is required by The Hartford if you purchase a coverage amount over \$25,000 for your spouse/domestic partner.
Dependent benefit	You may purchase additional coverage for your child(ren) in increments of \$2,000 up to a maximum of \$10,000 per child (children age birth to six months are limited to a reduced benefit of \$100).

Your Costs—for Yourself and Spouse/Domestic Partner

Age at birth-day in 2010	Cost per month for each \$1,000 of coverage	
	Non-smoker	Smoker
Under age 25	\$0.096	\$0.159
25 to 29	\$0.066	\$0.118
30 to 34	\$0.088	\$0.190
35 to 39	\$0.122	\$0.282
40 to 44	\$0.161	\$0.395
45 to 49	\$0.266	\$0.666
50 to 54	\$0.449	\$1.08
55 to 59	\$0.684	\$1.50
60 to 64	\$0.905	\$1.81
65 to 69	\$1.75	\$3.15
70 to 74	\$3.23	\$5.17
75+	\$6.53	\$8.49

Your Costs—for Covered Children

Benefit level	Cost per pay period
\$10,000	\$0.82

Disability Insurance

Disability insurance replaces a percentage of your income during extended periods of illness or injury that prevent you from performing your regular work. These benefits will coordinate with any state disability programs in which you are automatically enrolled (e.g., SDI in California).

Disability		
Employee Type	Maximum Monthly Benefit	Benefit Duration
Classified Prior to age 63	66.67% of pay to a maximum of \$5,000 per month	Prior to age 63, to normal retirement age or 48 months, whichever is longest
Certificated—with less than 5 years of service credit with CALSTRS Prior to age 63	66.67% of pay to a maximum of \$5,000 per month	Prior to age 63, to normal retirement age or 48 months, whichever is longest
Certificated—with 5 years or more service credit with CALSTRS Prior to age 66	66.67% of pay to a maximum of \$5,000 per month	Prior to age 66, 24 months
Administrators Prior to age 63	66.67% of pay to a maximum of \$10,000 per month	Prior to age 63, to normal retirement age or 48 months, whichever is longest

For benefit information for classified employees over the age of 63, or certificated employees over the age of 66, contact Human Resources.



Long Term Care Insurance — Voluntary Benefit

The voluntary Long-Term Care (LTC) insurance plan allows you to purchase financial protection in the event that long-term care for yourself or an eligible family member is needed due to a serious accident or chronic illness. This benefit can help pay for extended care at home, care in an assisted living facility, an adult care center, or a nursing home.

Employee Assistance Program (EAP)

SMCCCD recognizes there are times when employees may need assistance with work or life issues. The Claremont Employee Assistance Program (EAP) is a free, confidential service available to employees and their families.

SMCCCD's EAP benefit includes:

- Up to three, free face-to-face counseling sessions per issue per year for more serious concerns. Additional visits are available at discounted rates.
- 24/7 toll-free phone access to master's-level consultants.
- Online resources including a simple will kit, self-assessment tools and financial calculators.
- Booklets, audio tapes and in-depth articles from **www.claremonteap.com**.
- A dedicated Hispanic service center and printed resources in Spanish plus multi-lingual capabilities in 140 languages.



The EAP can help with a wide range of issues including:

- Emotional well-being
- Financial issues
- Legal issues
- Child and elder care issues
- School and college assistance
- Adoption assistance
- Pet care referrals
- Community resources
- Health and wellness
- Substance abuse

To use the EAP, please call (800) 834-3773 anytime day or night. Your call will be confidential.

Additionally, you have access to Claremont's Personal Advantage website at **www.claremonteap.com**. Click on Claremont Personal Advantage Online Access to create your account and use SMCCCD as the Company Name to access online tools.

Benefits Contacts

PLAN	Member Services	Website / Email
MEDICAL		
Blue Shield HMO	800-334-5847	www.blueshieldca.com
Kaiser	800-464-4000	www.kp.org
Anthem PERS Select/PERS Choice/PERS CARE	877-737-7776	www.anthem.com/ca
DENTAL		
Delta Dental	800-765-6003	www.deltadentalca.org
DeltaCare (PMI)	800-422-4234	www.deltadentalca.org/pmi
VISION		
Vision Service Plan (VSP)	800-877-7195	www.vsp.com
FLEXIBLE SPENDING ACCOUNT		
PayFlex	800-284-4885	www.healthhub.com
LIFE AND AD&D		
The Hartford	Contact Human Resources	www.thehartford.com
SHORT AND LONG TERM DISABILITY		
The Hartford	Contact Human Resources	www.thehartford.com
EMPLOYEE ASSISTANCE PROGRAM		
Claremont	800-834-3773	www.claremontep.com
HUMAN RESOURCES		
David Feune	650-358-6775	feune@smccd.edu
Mehrdad Elahi	650-358-6827	elahim@smccd.edu

For More Information

To learn more about a benefit or download benefit forms, visit www.calpers.ca.gov or visit the Human Resources section of the SMCCCD Website:

- Go to www.smccd.edu/portal
- Click District Downloads link



Glossary of Key Terms

Beneficiary – The person you designate to receive your life insurance proceeds in the event of your death.

Coinsurance – The member and insurance company share the cost of covered procedures in a specific ratio (e.g., member pays 20% and the insurance company pays 80%). This is primarily used in medical and dental PPO plans. If the plan has a deductible, coinsurance does not apply until it has been met.

Coordination of Benefits – When one person is covered by more than one insurance plan, the two plans “coordinate” coverage to determine which insurance carrier pays first and which pays second.

Copay / Copayment – A specific dollar amount you pay to the provider or pharmacy when receiving services or prescriptions.

Deductible – The amount you must pay before the insurance company begins paying benefits on your behalf. The deductible is generally waived for office visits and services that require a copayment, including prescription drugs.

Evidence of Coverage (EOC) – A document given to a member that contains an explanation of benefits and services available under the member’s insurance plan and outlines the rights and responsibilities of the plan.

Evidence of Insurability / Proof of Good Health – A questionnaire that insurance companies use to ask about the health of a participant. Depending on the responses, this may lead to the requirement of a physical exam. These forms are often used if you apply for voluntary benefits outside of your initial eligibility period or if you apply for an amount above the Guarantee Issue amount.

Explanation of Benefits (EOB) – A notice sent to the covered person after a claim for payment has been processed by the insurance company. The form explains the action taken on the claim. This explanation usually indicates the amount paid, the benefits available, reasons for denying payment or the claims appeal process.

Formulary – A list of preferred medications identified by the medical carrier. These medications are generally brand name drugs. Brand name drugs that are *not* on the formulary list usually require a higher copay. You can obtain a list of formulary medications by visiting the carrier websites referenced on the Benefits Contacts page.

Guarantee Issue – The amount of coverage (benefit) the insurance company is willing to provide regardless of your health. Guarantee Issue only applies if you enroll in the program when you are first eligible for coverage.

HMO – With this type of medical or dental plan, all care - except emergency services - must be coordinated through a Primary Care Physician (PCP) and/or medical group. Failure to coordinate care through a PCP may result in loss of benefit and greatly increase the amount of money that the member will have to pay for care. Each family member can have a different PCP and they can be changed monthly.

Imputed Income – The value of medical, dental and/or vision benefits provided to a domestic partner and the domestic partner’s children. The applicable amount is treated as taxable income to the employee and added back into an employee’s paycheck as taxable income. Imputed income also applies to the premiums that employers pay on your behalf for life insurance coverage amounts in excess of \$50,000. This premium is added to your gross income for tax purposes.

In-Network – All medical, dental and vision carriers have a designated network of doctors or dentists. You generally pay a lower percentage of the costs, resulting in less out-of-pocket cost.

Mail Order – A benefit that allows you to order certain maintenance drugs at a reduced cost. You receive multiple months’ worth of medication by mail.

Maximum Lifetime Benefit – The maximum dollar amount that an insurance carrier will pay in benefits on behalf of an insured individual during the course of their life.

Non-formulary – Any brand name medication that is not included on the formulary list.

Out-of-Network – Medical, dental and vision providers who do not agree to accept the negotiated rates offered by insurance companies.

Out-of-Pocket Maximum – Generally, the maximum amount of money a member will have to pay each year. The out-of-pocket maximum most often applies to coinsurance. An individual who meets the out-of-pocket maximum may still be responsible for copays.

PCP – Primary Care Physician. A doctor who is your first point of contact and who must coordinate your care and refer you to specialists. Primarily required by medical or dental HMO plans.

Preferred Provider Organization (PPO) – A type of medical or dental plan that gives members the flexibility to see any provider. If a member chooses an in-network provider or hospital, they will typically have to pay less out-of-pocket.

Pre-determination of Benefits – An estimate reflecting the amount of money an insurance company intends to pay on a

member's behalf for a particular procedure. This generally applies to medical and dental plans.

Premium – The per pay period and/or monthly cost of a benefit.

Pre-Tax – Employer contribution or employee money used to pay for certain benefits that is deducted from your pay before it is taxed. Pre-tax benefits can increase your take-home pay.

Post-Tax – Employer contribution or employee money used to pay for certain benefits that is deducted from your pay after it is taxed.

Qualifying Life Event – A significant life change, such as the birth of a child or loss of employment, that allows you to make changes to your benefit choices outside of Open Enrollment.

Reasonable and Customary – The range of usual fees for comparable services charged by the medical or dental professionals in a geographic area. If your provider charges more than the reasonable and customary fee, you may be responsible for paying the difference. This is often referred to as "Balance Billing".

Summary Plan Description (SPD) – A document that describes the features of an employer sponsored benefit plan. The Employee Retirement Income and Security Act (ERISA) requires that SPDs address several different aspects of the plan, such as participant rights.

Visually Necessary – Services or materials necessary to restore or maintain visual acuity (sharpness) and for which there is no less expensive professionally acceptable alternative. Contact lenses are deemed *visually necessary* if prescription eyeglasses physically cannot be worn or if they fail to provide a comparable level of sharpness than that which can be obtained by wearing contact lenses.

Your Rights

WHCRA

The Women's Health and Cancer Rights Act requires employer-sponsored group health plans to provide an annual notification of the provisions of the Act. All of the medical plan options provide coverage for medically necessary mastectomies, including related reconstructive surgery. This includes both reconstruction of the breast on which the surgery was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage is also provided for breast prosthetics and for any complications of the mastectomy, including lymphedemas.

Pre-Existing Condition Exclusion

Certain benefits will have a waiting period during which pre-existing conditions will be excluded. No payment will be made for services or supplies for the treatment of a pre-existing condition during a waiting period following either: (a) the insured person's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to medical benefits for children under the age of 19, or to conditions of pregnancy. Also if an insured person was covered under creditable coverage, as outlined in the insured person's Certificate, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the waiting period. If you are joining the plan and do not have creditable coverage, please review the contract provisions carefully when electing benefits.

Newborns' and Mothers' Rights

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Availability of Notice of Privacy Practices

SMCCCD provides health care benefits and related benefits to its eligible employees and their eligible dependents. By so doing, it creates, receives, uses, and maintains health information about plan participants which is protected by federal law (PHI). The Health Insurance Portability and Accountability Act (HIPAA) requires health plan(s) to provide plan participants and others with a notice of the plan's privacy practices with regard to the health information it creates and maintains in the course of providing benefits (Notice of Privacy Practices). This Notice of Privacy Practices describes the ways the plan uses and discloses PHI.

To obtain a copy of the plan's Notice of Privacy Practices, you should contact the member services department for your health coverage. Their contact information is located on your ID card. This is also generally available on their respective websites.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your Domestic Partner) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself or your dependents in medical insurance provided under the Plan if you or your dependents lose eligibility for that other coverage (or the employer stops contributing towards the other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Additionally, you may be entitled to special enrollment rights pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 if you or your dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility or if you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP. You may change your election consistent with such special enrollment right and the election does not need to be made within the 30 day period as long as the election is made consistent with the special enrollment.

Notice of Grandfathered Status

At this time, SMCCCD believes their plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 650-358-6775. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 22, 2010. You should contact your State for further information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/Pages/default.aspx Phone: 1-800-635-2570
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 602-417-5422	
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid	MONTANA – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084

IDAHO – Medicaid and CHIP	NEBRASKA – Medicaid
<p>Medicaid Website: www.accesstohealthinsurance.idaho.gov</p> <p>Medicaid Phone: 208-334-5747</p> <p>CHIP Website: www.medicaid.idaho.gov</p> <p>CHIP Phone: 1-800-926-2588</p>	<p>Website: http://www.dhhs.ne.gov/med/medindex.htm</p> <p>Phone: 1-877-255-3092</p>
INDIANA – Medicaid	NEVADA – Medicaid and CHIP
<p>Website: http://www.in.gov/fssa/2408.htm</p> <p>Phone: 1-877-438-4479</p>	<p>Medicaid Website: http://dwss.nv.gov/</p> <p>Medicaid Phone: 1-800-992-0900</p> <p>CHIP Website: http://www.nevadacheckup.nv.org/</p> <p>CHIP Phone: 1-877-543-7669</p>
IOWA – Medicaid	
<p>Website: www.dhs.state.ia.us/hipp/</p> <p>Phone: 1-888-346-9562</p>	
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Website: https://www.khpa.ks.gov</p> <p>Phone: 1-800-635-2570</p>	<p>Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm</p> <p>Phone: 1-800-852-3345 x 5254</p>
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
<p>Website: http://chfs.ky.gov/dms/default.htm</p> <p>Phone: 1-800-635-2570</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</p> <p>Medicaid Phone: 1-800-356-1561</p> <p>CHIP Website: http://www.njfamilycare.org/index.html</p> <p>CHIP Phone: 1-800-701-0710</p>
LOUISIANA – Medicaid	
<p>Website: www.dhh.louisiana.gov/offices/?ID=92</p> <p>Phone: 1-888-342-0555</p>	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
<p>Website: http://www.maine.gov/dhhs/oms/</p> <p>Phone: 1-800-321-5557</p>	<p>Medicaid Website: http://www.hsd.state.nm.us/mad/index.html</p> <p>Medicaid Phone: 1-888-997-2583</p>
MASSACHUSETTS – Medicaid and CHIP	<p>CHIP Website: http://www.hsd.state.nm.us/mad/index.html</p> <p>Click on Insure New Mexico</p> <p>CHIP Phone: 1-888-997-2583</p>
<p>Medicaid & CHIP Website: http://www.mass.gov/MassHealth</p> <p>Medicaid & CHIP Phone: 1-800-462-1120</p>	
MINNESOTA – Medicaid	NEW YORK – Medicaid
<p>Website: http://www.dhs.state.mn.us/</p> <p>Click on Health Care, then Medical Assistance</p> <p>Phone: 800-657-3739</p>	<p>Website: http://www.nyhealth.gov/health_care/medicaid/</p> <p>Phone: 1-800-541-2831</p>

MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	UTAH – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	VERMONT – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml Medicaid Phone: 1-800-359-9517 CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml CHIP Phone: 1-800-359-9517	Medicaid Website: http://www.famis.org/ Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://ihrsa/sites/DCS/COB/default.aspx Phone: 1-800-562-6136
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since January 22, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Important Notice from SMCCCD About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with SMCCCD and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. SMCCCD has determined that the prescription drug coverage offered by the SMCCCD medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current SMCCCD coverage will not be affected.

You may keep your current coverage if you elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will pay primary for coverage and Part D will be secondary. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current SMCCCD coverage, be aware that you and your dependents will be able to get this coverage back at the plan's next Open Enrollment or with a qualifying event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with SMCCCD and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SMCCCD changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get

a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 9/13/2010
Name of Entity/Sender: SMCCCD
Contact--Position/Office: Human Resources
Address: 3401 CSM Drive, San Mateo, CA 94402
Phone Number: 650-358-6775
