West Valley - Mission Community College District

HR HUMAN RESOURCES DEPARTMENT

BENEFITS

Benefits Overview Guide

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What's Inside

This brochure provides a summary of your benefit options and is designed to help you make your choices and enroll for your coverage. If you have any questions after you enroll, please call the benefit plan providers directly or log on to their Web sites. **Please refer to the Contact Information section of this booklet for details.**

Eligibility

You are eligible for the benefits program if you meet the minimum eligible employee guidelines as defined by WVMCCD. You are eligible for benefits with WVMCCD the first of the month following your date of hire. Your eligible dependents are defined as:

- Legally married spouses
- Qualified domestic partners
- Children up to age 26 for the medical plan (and not eligible for another group plan)
- Children up to age 25 for the dental and vision plans
- Stepchildren
- Legally adopted children
- Disabled children (Social Security determination required/no age maximum)
- Children of qualified Domestic Partnerships
- Any child for whom a Qualified Medical Child Support order that complies with all applicable laws has been issued

Certification of Dependents

If you would like to enroll your spouse or domestic partner for coverage, you must provide one of the following documents at the time of your request:

- *Marriage Certificate*
- *Domestic Partnership State Registration or Affidavit*

To enroll children for coverage, you must provide one of the following documents:

- *Birth Certificate*
- *Adoption Papers*

Before enrolling anyone as your dependent, verify that he or she qualifies under the plan rules. Enrolling an ineligible person as your dependent is a serious offense that will result in disciplinary action, which may include termination of employment.

How and When to Enroll

All enrollments are completed via our online benefits administration system, SmartBen. If you do not enroll within 30 days of your eligibility date, you will not be able to enroll for coverage until the next open enrollment period, unless you experience a qualified change in family status. (See Making Changes During the Year for details.) Benefit plan information is located under the "Plans and Policies" tab in SmartBen.

SmartBen Online Enrollment

SmartBen is our online enrollment tool that is available 24 hours a day, seven days a week. This system allows you to elect your benefit choices as a new hire or during Open Enrollment. After enrollment, SmartBen is available year-round to check your benefits information or record a family status change.

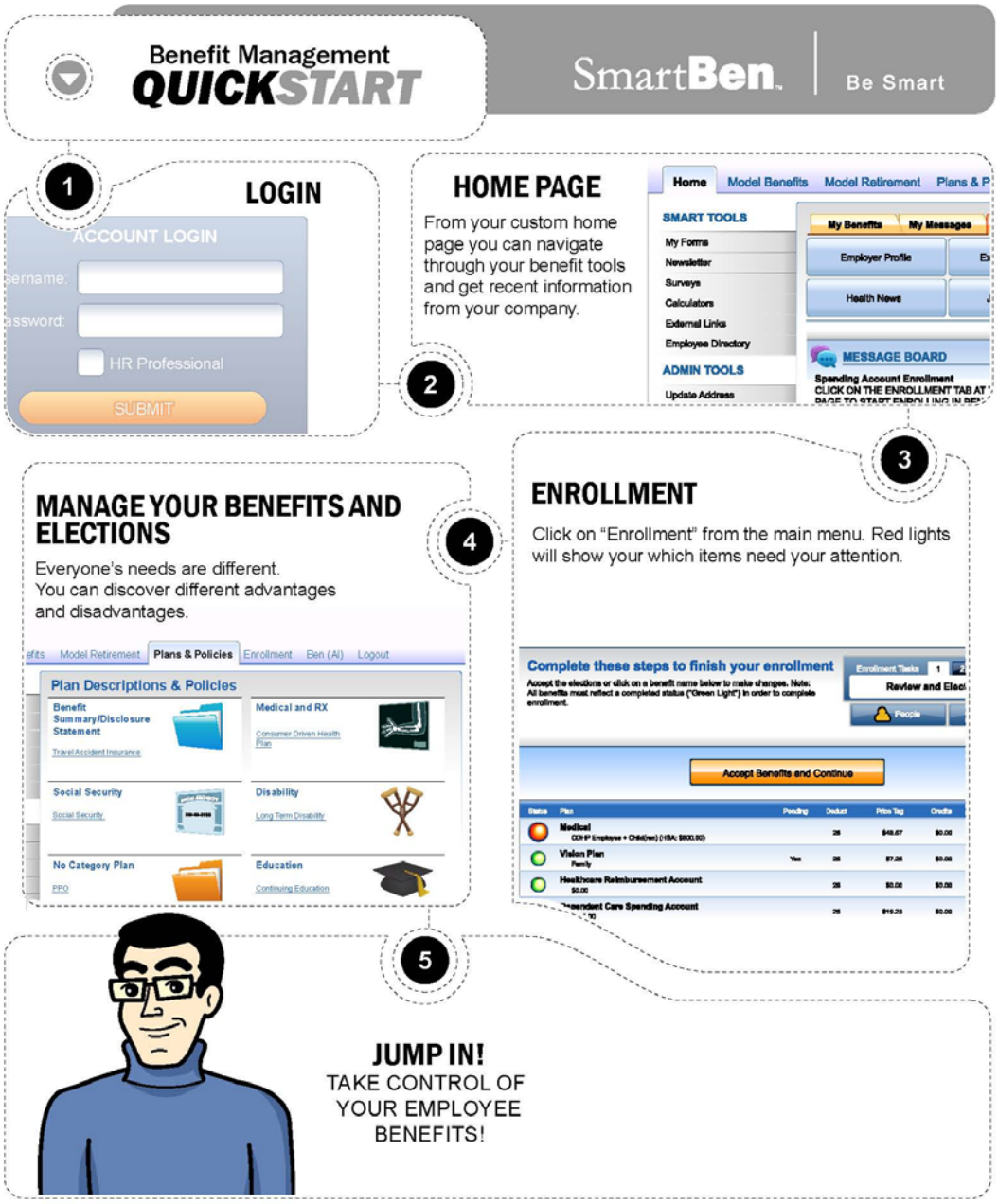
TIP: Use the TAB key to navigate. DO NOT use the ENTER key.

Logging In

1. Log onto www.smartben.com and enter your Username (wvm + datatel number) and Password (eight-digit date of birth MMDDYYYY format).
2. From the home page, click the Enrollment icon. TIP: Wait for all icons to appear before you click on Enrollment.
3. Click Begin Enrollment. You will now be able to review and elect your benefit options.
4. You will enter the enrollment process at the Benefit Manager page. To make changes to a benefit, click on a benefit name. To make an election, click on the option you want. Click the Confirm Election button at the bottom of the page when you are finished.

   People Manager is where your personal, spouse/dependent/beneficiary information is stored. Adding people into the People Manager **DOES NOT** assign them to coverage. You will assign them in the enrollment process. To return to enrollment, simply click Benefit Manager.
5. Once your elections are complete, each benefit will have a green light in the status box. To proceed to the next step, click the button labeled "Accept Benefits and Continue."

6. If you have not entered all required information, SmartBen will not process your enrollment. Click on any items in the Enrollment Task List and SmartBen will take you to the required page for corrections. Make your corrections, click Submit, Enroll or Save, whichever is applicable. Be sure to review any Important Information notes on this task page and click Continue.
7. You will now have the opportunity to Review your Confirmation. Examine your elections thoroughly, including dependent and beneficiary assignments, and enter your initials to acknowledge your agreement before clicking Continue at the bottom.
8. Once finished, you can select Print for a copy of your Confirmation Statement.



Your username is "WVM" + your employee ID number (e.g. wvm1234567). Your default password is your date of birth in mmddyyyy format (e.g. 06101977 for June 10, 1977).

Frequently Asked Benefit Questions

Q. Will there be a deduction taken from my paycheck for my benefit coverage?
A. Beginning 7/01/2011, WVMCCD implemented a Benefits Cap of $18,050 annually to contribute towards each employees' annual health care premiums (medical, dental, vision and long term disability), including covered dependents. If you are a Percentage Employee the Benefits Cap will be pro-rated to the percentage you work full-time. Please review the Health Care Plan Options & Costs sheet or your Benefit Summary in SmartBen to determine your monthly contribution, if any. Deductions for medical, dental, vision, long-term disability and life insurance are collected one month in advance. Voluntary plans (i.e. flexible spending accounts, life insurance, AD&D) are subject to employee deductions.

Q. What documentation will I need to submit to add a dependent?
A. In addition to their basic information:
- Child dependent - birth certificate
- Spouse - marriage certificate
- Domestic Partner - documents listed in the Domestic Partner Affidavit

Q. How do I choose my medical and dental plans to ensure that I select the best plan(s)?
A. First, review the informational materials in your benefits packet and on the SmartBen website under "Plans & Policies" to evaluate which plans would meet you/your family's current medical and dental needs. Some individuals prefer the convenience of having a co-payment and decide to choose an HMO plan. Others prefer to pay deductibles for the flexibility of going to participating and non-participating providers and therefore enroll in PPO plans. Regardless of which plans you choose, please keep in mind that all of the plans, whether they are HMO or PPO, are designed to provide comprehensive health coverage to you and your family.

Q. What is the difference between an HMO and a PPO?
A. HMO (Health Maintenance Organization) offers specific participating network providers that members select for their health care. Providers outside of the network are not covered, unless the provided services are considered emergency in nature. PPO (Preferred Provider Organization) also offers participating network providers, however, a member may access care outside of the designated network. An advantage in utilizing network providers is benefits are covered at a higher rate than non-network providers.

Q. How do I find participating providers who are on my plans?
A. The benefit carrier web sites provide this information. Please refer to the Contact Information sheet on the last page of this Benefits Overview Guide.

Q. What are my benefit policy numbers, customer service numbers, and web addresses?
A. Please refer to the Group Numbers sheet located on the home page of SmartBen under "News".

Q. When will I receive my benefit identification cards?
A. Kaiser/Blue Shield/Envision Rx Options/Delta Care PMI - Your identification cards will arrive in 7-10 working days from the date that you return your completed enrollment forms to the benefits specialist.

Delta Dental (PPO)/Vision Service Plan – Cards are not issued by these carriers. Please provide your health care practitioners with your social security and your group number.

Q. What if I'm not happy with the medical and/or dental plan? May I change my plans?
A. The opportunity to change your plans is offered during our open enrollment period, held in April of each year. Changes made during Open Enrollment will be for a July 1st effective date.

Q. May I extend my benefit coverage if I leave the District?
A. Yes, you have the option to continue your health care coverage through COBRA. Details on COBRA are mailed to your home address by our Cobra Administrator, Employee Benefits Corporation (EBC).

Making Changes During the Year

The choices you make when you first become eligible remain in effect for the entire plan year. Once you are enrolled, you must wait until the next open enrollment period to change your benefits or add coverage for dependents, unless you have a qualified change in family status as defined by the IRS.

- Change in marital status
- Change in number of dependents (birth, adoption, death)
- Change in spouse or dependent's eligibility under an employer's plan
- Change in employment status that changes eligibility status (change in work schedule such as termination, a decrease in hours worked, change in residency that affects accessibility to current plan)
- Change in cost or coverage (significant cost increase, open enrollment of spouse under other employer's plan)
- Change in eligibility for a state program such as Medicaid

When you experience a family or employment status change, the benefit changes you request must be consistent with and due to your change in status. For example, if you have a newborn child, you may not also add other dependents that you did not previously add to the plan. If you need assistance determining what changes are allowed, contact Human Resources.

Any benefit change needed due to a qualifying status change event must be made within 30 days of the event (or within 60 days of a loss of Medicaid/CHIP coverage, or within 60 days of gaining eligibility for a state's premium assistance program under Medicaid or CHIP).

For example, if your child is born on November 15th, they would become effective on the plan December 1st. You would need to submit this change to Benefits no later than December 15th. If you miss this deadline, your dependent would not be eligible for coverage until the next open enrollment.



Stay Healthy with Medical Coverage

Nothing is more important than the health of you and your family. That is why West Vallley-Mission Community College District offers you medical plan choices designed to help you get the care you need at a price you can afford. You have the choice between an HMO or a PPO plan with Blue Shield of California or the option to enroll with Kaiser Permanente. See the table below for a comparison of the plans and how they work:

	Blue Shield PPO		Blue Shield HMO	Kaiser Permanente HMO
	Preferred	Non-Preferred	In Network Only	In Network Only
How does my plan work?	This plan operates as a preferred provider organization (PPO). You choose which doctors and hospitals provide your care. Coverage may be higher and costs will be lower when you visit "In-Network" doctors and facilities. If you access providers Out-of-Network, they may bill you for amounts over the Blue Shield contracted rate (this is known as Balance Billing). These charges are your responsibility. In addition, it is your responsibility to ensure whether your providers are In-Network or Out-Of-Network.		A Health Maintenance Organization (HMO) requires you select a Primary Care Physician (PCP), who will be responsible for coordinating your care. Whenever you need to see a specialist, you must contact your PCP for a referral.	This plan requires that you acess only Kaiser providers for your care. Only Emergencies are covered if non-Kaiser providers are utilized.
Can I choose my doctor?	Yes, you can choose any provider you prefer. However, you will save money if you choose Preferred doctors.		Yes, only those listed as Primary Care Physicians (PCP).	Yes, only those at Kaiser facilites.
What is my deductible?	$250 individual $750 family	$250 individual $750 family	None	None
What is the cost for preventive care services (e.g., well baby care, well woman exams, routine physicals)?	$0 copay (deductible waived)	20% after deductible	$0 copay	$0 copay
What is the cost for a routine and specialist office visit?	$10 copay (deductible waived)	20% after deductible	$5 copay $30 copay Access+ Specialists	$5 copay
What is the cost for an emergency room visit?	$50 copay ($150 copay if admitted)	$50 copay ($150 if admitted) plus 20%	$25 copay (waived if admitted)	$5 copay
What is the cost for INPATIENT hospitalizations?	$150 copay per admission after deductible	20% after deductible	$0 copay	$0 copay
What is the cost for OUTPATIENT hospitalizations?	$0 copay after deductible	20% after deductible	$0 copay	$5 copay
What is the cost for prescription drugs?	THE BENEFIT IS THROUGH ENVISION RX: Retail (30 day supply) $5 generic; $10 single-source brand formulary; $20 multi-source formulary; Mail-order (up to a 90 day supply $0 copay)	THE BENEFIT IS THROUGH ENVISION RX: Pay full price at the pharmacy and you then submit the claim to Envision Rx for reimbursement	Retail or Mail-Order: $6 copay Specialty drugs require a $30 copay	$5 copay for a 100-day supply
Other services	Benefits vary by service	Benefits vary by service	Benefits vary by service	Benefits vary by service
What are my out-of-pocket maximum costs?	$0 single $0 family	$1,000 single $3,000 family	$1,000 single $2,000 family	$1,500 individual $3,000 family

Cash in Lieu of Medical Benefits

Employees of West Valley-Mission Community College District have the option to decline the district medical insurance and receive cash in lieu. Employees may choose to deposit the cash into a Tax Shelter Annuity (403B), CalPERS 457 plan or receive the cash as an addition to pay. Please note that this benefit will be subject to income tax. If you choose to deposit the contribution into a TSA or 457 plan, the only taxes that will be deducted are FICA (Social Security) and Medicare.

Depending on the option chosen, employees who work 100% of full-time will receive an amount of $3,600 annually. Employees who work a percentage of full-time will receive a prorated amount.

Smile Brightly with Dental Coverage

The employees of West Valley-Mission Community College District have the ability to choose between two dental plans offered through Delta. Please review the options below regarding the PPO and DeltaCare HMO benefits offered through Delta.

	Delta PPO Incentive Plan		DeltaCare HMO Plan
	In Network	**Out of Network**	**Preferred**
How does my plan work?	This plan operates as a preferred provider organization (PPO). You choose which dentists provide your care. Coverage may be higher and costs will be lower when you visit "In-Network" providers. It is your responsibility to ensure whether your providers are In-Network or Out-of-Network.		You may only access providers in the participating provider network.
What does an "Incentive Plan" mean?	Most benefits start at 70% depending on the service. (Prosthodontics remain at 50% for the duration of the plan). If you visit the dentist one time during the year, the benefit will increase by 10% for the following year. This will occur each year until the benefit reaches 100%. If you do not visit the dentist during the year, your benefits will remain at the current level and will not decrease unless there is a lapse in coverage.		n/a
Annual Deductible (waived for preventive services)	$100 single $300 family	$100 single $300 family	None
Annual Maximum	$1,600 per person	$1,500 per person	None
Diagnostic & Preventive Oral exams, cleanings, x-rays, flouride treatment	70% - 100%	70% - 100%	Scheduled copays based on services
Basic Services Fillings, extraction, root canals	70% - 100%	70% - 100%	Scheduled copays based on services
Major Services Crowns, inlays, onlays, cast restorations	70% - 100%	70% - 100%	Scheduled copays based on services
Prosthodontics Dentures and bridges	50%	50%	Scheduled copays based on services
Orthodontics[(1)] up to age 18 over age 18	 Not Covered Not Covered	 Not Covered Not Covered	 $1,600 Copay $1,800 copay

[(1)]Please refer to the plan summary for a complete listing of Orthodontia coverage, limitations and exclusions.

See Clearly with Vision Coverage

The plan listed below through VSP is for employees who enroll in a Blue Shield Medical plan. If you enroll in Kaiser, your vision coverage is through Kaiser with coverage for eye exams and glasses or contact lenses. Kaiser members pay $5 for an exam and are allowed $175 for materials every 24 months.

For Blue Shield members, the VSP coverage is as follows:

	In Network	Out of Network
	You pay:	Plan reimburses you up to:
Exam every 12 months	$25 copay	$45
Frames every 24 months	Amounts over $120 allowance	$47
Lenses		
Single vision	$0 after copay	$45
Bifocal	$0 after copay	$65
Trifocal	$0 after copay	$85
Contact lenses every 24 months - in lieu of lenses		
Medically necessary	$0 after copay	$210
Elective	Amounts over $120 allowance	$105

Accessing care is simple! If you do not already have a VSP contracted provider, you may search for one at www.vsp.com or by calling VSP at (800) 877-7195.
Once you've found a doctor, call their office to make an appointment. When making the appointment, you will need to provide the following information:

- Your name and that you're a VSP member
- Your VSP member group or employer
- Your Social Security number or other identification number
- Your date of birth

If you are making an appointment for a dependent, provide the member's name, member's SSN and *dependents* date of birth. Please note that you will not receive an ID card for the VSP coverage.

Lower Your Taxes with Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) are a tax-saving way to pay health care and dependent care expenses that you would typically pay out-of-pocket (e.g., deductibles, copays, day care expenses). The FSAs let you pay these expenses with pre-tax dollars. Each year that you would like to participate in the FSAs, you must elect the amount you want to contribute to either or both of the FSAs. Your contributions will be deducted from your paychecks in equal installments throughout the year and deposited into your account(s). **You may contribute up to $2,500 to the Health Care FSA and $5,000 ($2,500 if you are married and file your taxes separately) to the Dependent Care FSA**. Both accounts function separately. When you have eligible expenses, you submit a claim for reimbursement from your FSAs.

Eligible Expenses

Eligible expenses for the Health Care FSA include medical, dental, and vision expenses not covered under your health care plans. Eligible dependent care expenses for the Dependent Care FSA are those that allow you and your spouse (if you are married) to work or attend school full time. These services generally include day care, babysitters, most day camps, and caregivers for disabled dependents.

What is a Benny Card?

• A Debit MasterCard that will debit your Health FSA when used to pay for eligible expenses at participating retailers. This eliminates you having to pay out-of-pocket for qualified expenses.

• Please note that you may be asked to substantiate claims per IRS Guidelines – SAVE ALL RECEIPTS so they can be submitted if requested.

Important Rules to Keep in Mind

FSAs offers sizeable tax advantages. The trade-off is that these accounts are subject to strict IRS regulations, including the following:

- The IRS has a strict "use it or lose it rule": If you do not use the full amount in your FSAs by the end of the plan year, you will lose any remaining funds.
- All claims must be submitted within 90 days of the end of the plan year.
- Any unused funds can be rolled over for 2 1/2 months after the end of the plan year.
- Once you enroll in the FSAs, you cannot change your contribution amount during the year unless you experience a qualified status change.
- You cannot transfer funds from one FSA to another.

Why Enroll?

- By putting money aside pre-tax, this lowers your taxable income – which in turn may increase your spendable income!
- Funds can be used for planned and unplanned eligible health care expenses. You don't need to earmark funds for a specific purpose.

Access My Account Assistant on www.ebcflex.com to manage your FSA account, obtain account balances, download forms and review claims.

Transportation FSA

The Transportation FSA is another method allowed to use pre-tax dollars for your daily commuting expenses, including transit and parking. This could save you as much as 30% on transit and parking – which adds up to a very powerful benefit and a substantial take-home bonus to your paycheck. West Valley-Mission Community College District allows you to enroll in the Transit benefit or the Parking benefit.

Transit Benefit

When you use public transportation for your daily commute (e.g., trains, buses, subways, vanpooling), you're making a smart choice. You are choosing a commuting solution that reduces fuel, congestion and pollution. If you choose to enroll in this benefit, you are able to set aside $130 per month, pre-tax, to be used to purchase transit passes in either of two forms:

- Commuter Check Vouchers
  - Use to purchase transit passes, tickets, cards, etc.
  - Valid for 15 months
- Commuter Check Card PrePaid MasterCard
  - Participant uses card to pay for transit

If you access vanpooling, the monthly amount is combined with the $130 above. A vanpool is considered:

- Transportation between residence and place of work in a Commuter Highway Vehicle (CHV)
- Seating capacity of at least 6 (not including driver)
- At least 80% of the miles are for transportation between residences and place of work
- At lease half the seating capacity of that van must be filled
- The van can be employer operated, employee operated, private or public

Parking Benefit

Parking your vehicle can be expensive. Thanks to the Parking Benefit, now you can minimize that cost. You can use this benefit to pay for parking at or near the business premises or at or near a location from which the employee commutes to work via mass transit. If you enroll in this benefit, you can set aside $250 per month on a pre-tax basis. This amount is separate from the Transit Benefit above. You can choose to receive the benefit as follows:

- Direct Pay – WiredCommute pays parking provider directly and participant chooses parking lot
- Commuter Check Voucher – WiredCommute provides voucher for participant to pay provider directly
- Commuter Check Card PrePaid MasterCard – Participant uses this card to pay for parking
- Cash Reimbursement – Reimbursements are done through an online reimbursement form

Important information regarding the Parking Benefit:

- The following parking situations are **NOT** eligible under this benefit: Temporary work locations, parking fee for a conference or meeting, a one day parking fee
- If you carpool and park, only the **prime member** (person with assigned parking spot) is entitled to the Parking Benefit

Access the Commute Ease / WiredCommute ordering platform on www.ebcflex.com to manage your FSA account, obtain account balances, download forms and review claims.

Protect Your Loved Ones with Life and Accidental Death and Dismemberment Insurance

Providing economic security for your family if you die, become disabled, or experience an injury or illness is a major consideration in personal financial planning. West Valley-Mission Community College District allows you the ability to purchase coverage for you and your dependents. You may purchase the following amounts of coverage through payroll deductions. Please note that these policies require approval by MetLife before being issued. Payroll deductions will not begin until the District has received notification of approval from MetLife.

The application, rates and Statement of Health can be found on SmartBen, under "Plans and Policies."

	Life Insurance	Accidental Death & Dismemberment (AD&D)
Employee		
Maximum	$500,000	$250,000
Guarantee Issue (amount that does not require MetLife Underwriting approval if a newly eligible employee)	$250,000	$250,000
Spouse		
Maximum	$150,000 or 50% of EE amount (whichever is less)	50% of EE amount
Guarantee Issue	$20,000	n/a
Children		
Maximum	$10,000	15% of EE amount
Guarantee Issue	n/a	n/a

Prepare for the Unexpected with Disability Coverage

West Valley-Mission Community College District believes that long-term disability (LTD) coverage is important because anyone at any age may become injured or ill for an extended period of time. LTD coverage will replace 66 2/3% of your base salary to a monthly maximum of $5,000 if you are disabled for more than 90 days and are unable to work. LTD benefits are offset with other sources of income, such as Social Security and Workers' Compensation. Preexisting condition exclusions apply. A copy of the Certificate of Coverage can be found on SmartBen, under "Plans and Policies."

Class 1	Certificated employees with 5+ years of credited California service	
	Age at Disability	Maximum Benefit Period
	All Ages	1 year
Class 2	All employees not eligible in another class	
	Age at Disability	Maximum Benefit Period
	< 60	To age 65 but not less than 5 years
	60 - 64	5 years
	65 - 69	To age 70 but not less than 1 year
	70+	1 year

Get Help from the Employee Assistance Program (EAP)

Because unresolved personal issues can affect every aspect of one's life, including work performance, West-Valley Mission Community College District automatically provides you and your family with an Employee Assistance Program (EAP) at no cost to you. Call the EAP at (800)834-3773 for confidential assistance with nearly any personal matter you may be experiencing. Licensed counselors are available 24 hours a day, 7 days a week, and can provide you with access to face-to-face counseling (up to three sessions per person per event), legal advice, financial consultation, medical advice, dependent care referrals, and other community referrals.

Counseling Services

- Depression and stress
- Co-worker conflicts
- Grief and loss
- Marital or family issues
- Alcohol/Substance abuse issues

Dependent Care Referral

- Referrals to child or elder care providers
- Referrals to home health care providers
- Tips on interviewing and monitoring caregivers
- Relocation and adoption information
- Child/Summer day camp

Legal Consultation

- Simple Will kit
- Divorce and custody
- Small claims or personal injury
- Personal injury
- Drunk driving offenses
- Criminal offenses
- Adoption Assistance information

Planning for your Future with Retirement Plans

It is never too late to plan for your retirement and West Valley-Mission Community College District offers you options to help you reach your goals.

You can enroll in a 403(b) plan as well as a 457 plan. Please refer to the Contact Information at the back of this booklet for more information on the contacts for enrollment.

Annual limit for participants UNDER age 50	**457**	**403(b)**	**Total**
	$17,500	$17,500	$35,000
Annual limit for participants OVER age 50	**457**	**403(b)**	**Total**
	$23,000	$23,000	$46,000

Please note that the annual limits for the 457 and 403(b) are subject to change annually.

Everyday Ease with Credit Unions

As an employee of West Valley-Mission Community College District, you have access to two Credit Unions: Santa Clara County Federal Credit Union and Commonwealth Central Credit Union.

Through these establishments, you have access to free/discounted checking accounts, auto and mortgage loans, credit cards, financial workshops and much more.

Please contact the Benefits Department for more information on these two Credit Unions.

Important Notices

COBRA Continuation Coverage

COBRA, which stands for "Consolidated Omnibus Budget Reconciliation Act," gives you and your dependents the right to continue health care coverage for a specific time if your coverage through WVMCCD ends. In accordance with COBRA, you (and/or your covered dependents) have a right to continue your health care coverage in the event you (or your dependents) are no longer eligible for coverage through the WVMCCD benefits program. There are several instances in which COBRA continuation is available; these instances are referred to as "qualifying events." Examples of qualifying events include:

- You end your employment with WVMCCD
- You are no longer eligible for benefits due to a reduction of work hours
- You and your spouse divorce or become legally separated
- Your dependent child reaches the maximum age for coverage

Generally, COBRA coverage is available to your for up to 18 months (an additional 18 months may be available in certain circumstances). To receive this coverage, you must enroll for benefits in a timely manner and pay the required premium. The amount charged will be equal to the full premium plus a 2% administration fee.

If a qualifying event occurs and WVMCCD is aware of it, WVMCCD's COBRA administrator will send you the required COBRA enrollment materials. For other qualifying events that only you are aware of, such as a divorce, it is your responsibility to report the event to WVMCCD within 60 days.

Opportunity to Enroll or Reenroll Dependents Who are Under Age 26

If you have a dependent whose coverage ended, or who was denied coverage (or was not eligible for coverage), because coverage for dependent children under the plan previously ended before they were age 26, they are eligible to enroll or reenroll in our medical plan. You may request enrollment for such children who are under age 26 for 30 days from the date this notice is received. Enrollment will be effective as of the first day of our first plan year beginning on or after September 23, 2010, even if that results in retroactive enrollment. For more information contact Human Resources or call the medical carrier at the telephone number on your insurance identification card.

Lifetime Limit Not Applicable and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under our medical plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Human Resources or call the medical insurance carrier at the telephone number on your identification card.

Notice on Patient Protections

Our medical HMO plan generally allows the designation of a 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 medical carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier at the number listed on your identification card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the medical insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. 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. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier at the number listed on your identification card.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator.

Important Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.
If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or call your plan administrator.
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Important Notices

Children's Health Insurance Program (CHIP) Reauthorization Act of 2009

Effective April 1, 2009, employees and dependents who are eligible for coverage under the medical plan, but are not enrolled, will be permitted to enroll in the plan if they lose eligibility for Medicaid or CHIP coverage or become eligible for a premium assistance subsidy under Medicaid or CHIP.

Individuals must request coverage under the plan within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

CHIPRA allows states to offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage.

Some states offer a premium assistance subsidy. See the CHIPRA notice in this section for further details on premium assistance.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

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 that offers assistance, you can contact your State Medicaid or CHIP office to find out if premium assistance is available for you.

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 visit **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.**

Many states offer assistance. A detailed contact list with phone numbers and websites is available and is updated periodically by the U.S. Department of Labor and the U.S. Department of Health and Human Services. This detailed notice is available during open enrollment or upon request at any time during the year.

HIPAA Notice of Privacy Practices

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy regulations, this is a reminder that a copy of our company's HIPAA Privacy Practices is available upon request. You may request a copy of this notice by contacting Human Resources.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Notices

Medicare Part D – Important Notice 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 West Valley Mission Community College District 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. The prescription drug coverage offered by Blue Shield and Kaiser, 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 October 15 through December31. 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.

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 under the group health plan 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 19 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 Human Resources 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 IMS 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).

Contact Information

Benefit	Contact	Telephone	Web Address
Medical			
Blue Shield PPO	Blue Shield	(800) 334-9849	www.blueshieldca.com
PPO Prescription	Envision Rx	(800) 361-4542	www.envisionrx.com
Blue Shield HMO	Blue Shield	(800) 424-6521	www.blueshieldca.com
Kaiser Permanente	Kaiser Permanente	(800) 464-4000	www.kaiserpermanente.org
Dental			
Delta PPO	Delta Dental	(866) 499-3001	www.deltadentalca.org
DeltaCare HMO	DeltaCare	(800) 422-4234	www.deltadentalca.org
Vision	VSP	(800) 877-7195	www.vsp.com
Flexible Spending Accounts	EBC	(800) 342-2126	www.ebcflex.com
Life and AD&D	MetLife	(800) 638-6420	www.metlife.com
Long Term Disability	Unum	(800) 421-0344	www.unum.com
Employee Assistance Program (EAP)	Claremont EAP	(800) 834-3773	www.claremonteap.com
403(b)	403b Compare		www.403bcompare.com
	EBSG (Third Party Administrator)	(866) 474-1144	www.ebenefitsservice.net
	Payroll Department	(408) 741-2141	
CalPERS 457 (administered by ING) 181 Metro Drive, Suite 520 San Jose, CA 95110	Customer Service - ING CalPERS Planning Info	(800) 260-0659 (888) 225-7377	www.calpers.ingplans.com www.calpers.ca.gov
CalSTRS	CalSTRS Planning Info	(888) 394-2060	www.calstrs.ca.gov
SmartBen	SmartBen		www.smartben.com
Benefits Advocate	**BB&T Benefits Advocate**	**(800) 914-5096**	**BenefitsAdvocate@BBandT.com**

Benefits Advocate

Benefits Advocate is available to assist you with your benefits-related questions and issues. When there is confusion or concern with your insurance, reach out to Benefits Advocate for assistance. This service is brought to you by BB&T Insurance Services.

- Finding a contracted provider
- Resolving referral problems
- Researching denied claims
- Obtaining pre-authorizations
- Explaining an EOB
- Answering COBRA or out-of-area questions
- Complex insurance forms
- Disability claims
- Life Insurance claims
- Filing grievances or appeals
- Coverage while traveling
- Flexible Spending Accounts

(800) 914-5096 or BenefitsAdvocate@BBandT.com Monday – Friday, 8:00 a.m. – 5:00 p.m., except major holidays

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Prepared by:

BB&T Insurance Services

BB&T John Burnham Insurance

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.