SAN MATEO COUNTY
COMMUNITY
COLLEGE DISTRICT

2022 Benefits Information Guide

Understanding your Options

Hello!

Welcome to your 2022 Benefits Information Guide.

At San Mateo County Community College District (SMCCCD), we recognize the importance of a comprehensive benefits program and are committed to providing you with benefits that meet the needs of you and your family. We offer a range of plans that help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool to help you become familiar with the plans and programs that you and your family can enroll in for the plan year.

Enclosed you will find details about:

- Step by step instructions regarding enrollment
- Summary information about each medical, dental and vision benefit option
- Additional benefits such as life insurance, employee assistance program (EAP), retirement plans, and other voluntary programs
- Directory and contact information, in case you have questions

Sincerely,

David Feune
Director of Human Resources

TIP

Questions about COVID-19? Please refer to our COVID-19 website at https://covid-19.smccd.edu/

Enrollment

Medical Plan Choices

SMCCCD offers regular employees a choice of several 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 https://www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates/zip-search, to determine which plans are available.

Comparing Your Options: Search Health Plans

Search Health Plans at myCalPERS account at https://my.calpers.ca.gov/web/ept/public/systemaccess/selectLoginType.html
Access your myCalPERS account for a convenient way to evaluate your health plan options and make a decision about which plan is best for you and your family. With this easy-to-use health plan comparison tool, you can weigh plan benefits and costs, and view how the plans compare.

You can access your account 24/7 to help you make health plan decisions at any time. You can use it to:

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

Get customized assistance selecting the health plan that is right for you and your family by logging into your myCalPERS account at my.calpers.ca.gov, selecting the "Health" tab and then selecting "Search Health Plans."

Who can Enroll?

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, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) and unregistered domestic partner (hereinafter referred to as "registered and unregistered domestic partner") and/or eligible children.

When Does Coverage Begin?

Your enrollment choices remain in effect through the end of the benefits plan year, (through December 2022). Benefits for eligible new hires will commence as outlined below:

Eligibility Date	Benefit Plan
Immediately upon your date of hire or date of transfer to a benefit eligible position	CalPERS CalSTRS
The first day of the month following your date of hire (within 60 days of employment, otherwise there is a 90-day waiting period)	All non-retirement plans including medical, dental, vision, life and disability

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a qualifying life event during the plan year. Please review details on IRS qualified life events for more information.

How do I Enroll?

Download Forms/Contact HR

- After reviewing your options, complete the enrollment forms and submit via dropbox https://www.dropbox.com/request/jNC7rotNPqL2652wfnEy
- If you have questions when completing your enrollment forms, contact Jessica Esclamado, esclamadodavidj@smccd.edu.

What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's/registered domestic partner's loss or gain of coverage through our organization or another employer.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents.

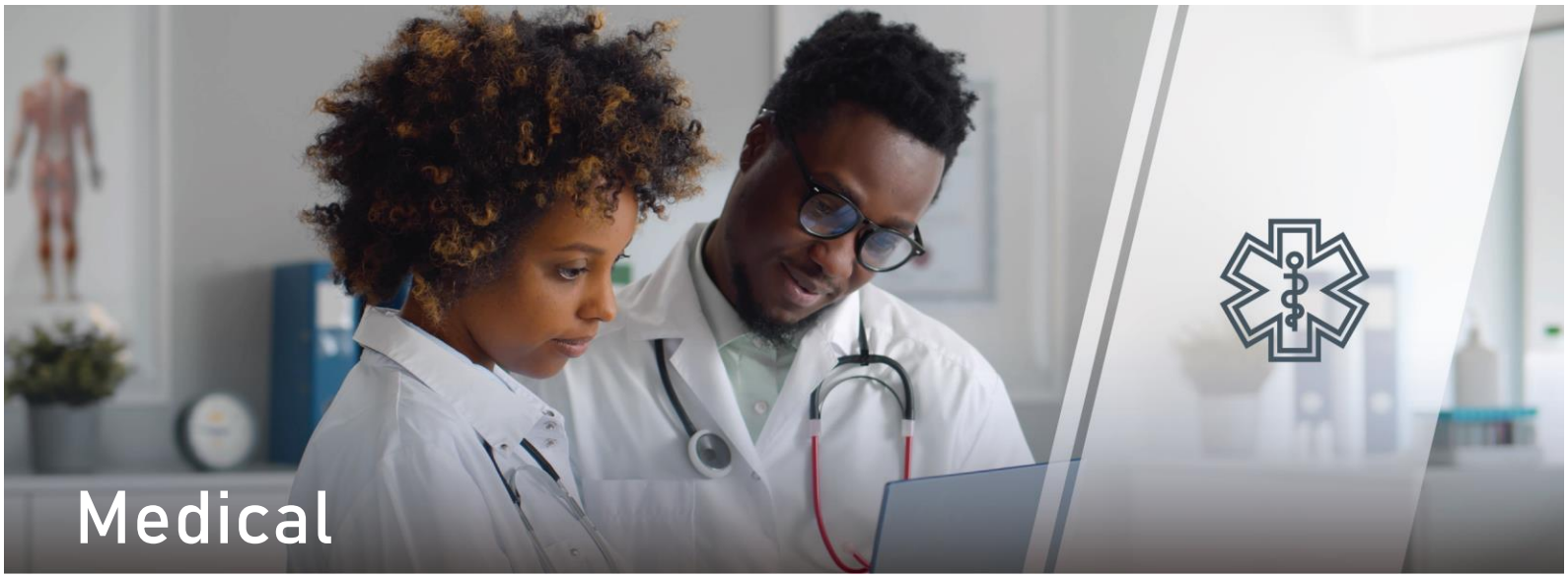
Do I Have to Enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

You may elect to "waive" medical, dental, or vision coverage if you have access to coverage through another plan. To waive coverage you must notify Human Resources. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be during Open Enrollment (generally in September each year) or if a qualifying status change occurs.



Medical

What are my Options?

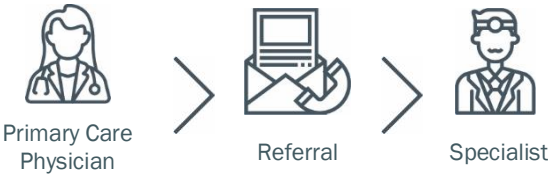
Use the chart below to help compare medical plan options and determine which would be the best for you and your family.

	HMO	HMO	PPO
	Kaiser	**Health Net, Anthem Blue Cross & Blue Shield Access+**	**Anthem PERS Platinum & Gold**
Required to select and use a Primary Care Physician (PCP)	**Yes**	**Yes**	**No**
Seeing a Specialist	Kaiser referral required in most cases	PCP referral required in most cases	No referral required
Deductible Required	No	No	Yes, in most cases
Finding a Provider	Contact Member Services	Contact Member Services	Contact Member Services
Claims Process	Usually handled by Kaiser	Usually handled by Health Net or Anthem Blue Cross	PPO providers will submit claims You submit claims for other services
Other Important Tips	This plan requires that you see a doctor in Kaiser to receive coverage Out-of-Network services without proper PCP referral will not be covered Emergencies covered worldwide	This plan requires that you see a doctor in a specific network to receive coverage Out-of-Network services without proper PCP referral will not be covered Emergencies covered worldwide	You may choose in or out of network care, however in-network care provides you a higher level of benefit Emergencies covered worldwide

Please note the above examples are used for general illustrative purposes only. Please consult with your Human Resources Department for more specific information as it relates to your specific plan.

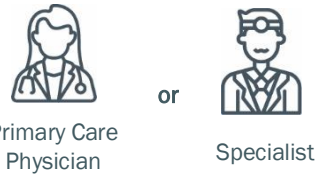
USING AN HMO

In-Network



USING A PPO

In-Network or Out-of-Network



Cost Breakdown The rates below are effective January 1, 2022.

Note, other plans may be available depending on your zip code.

Use CalPERS Health Plan Search by zip code tool.

Coverage Level	Premium	Academic Supervisors, & Administrators		AFT (Regular Faculty)	
		Portion Paid by District	Out of Pocket	Portion Paid by District	Out of Pocket
HMO Plans					
Anthem Blue Cross Traditional					
Employee Only	$1,304.00	$889.00	**$415.00**	$875.00	**$429.00**
Employee + 1	$2,608.00	$1,462.00	**$1,146.00**	$1,444.97	**$1,163.03**
Employee + 2 or More	$3,390.40	$1,969.00	**$1,421.40**	$1,878.41	**$1,511.99**
Anthem Blue Cross Select – Limited Network					
Employee Only	$1,015.81	$889.00	**$126.81**	$875.00	**$140.81**
Employee + 1	$2,031.62	$1,462.00	**$569.62**	$1,444.97	**$586.65**
Employee + 2 or More	$2,641.11	$1,969.00	**$672.11**	$1,878.41	**$762.70**
Blue Shield Access+					
Employee Only	$1,116.01	$889.00	**$227.01**	$875.00	**$241.01**
Employee + 1	$2,232.02	$1,462.00	**$770.02**	$1,444.97	**$787.05**
Employee + 2 or More	$2,901.63	$1,969.00	**$932.63**	$1,878.41	**$1,023.22**
Kaiser Permanente					
Employee Only	$857.06	$889.00	**$0.00**	$875.00	**$0.00**
Employee + 1	$1714.12	$1,462.00	**$252.12**	$1,444.97	**$269.15**
Employee + 2 or More	$2,228.36	$1,969.00	**$259.36**	$1,878.41	**$349.95**
HealthNet SmartCare					
Employee Only	$1,153.00	$889.00	**$264.00**	$875.00	**$278.00**
Employee + 1	$2,306.00	$1,462.00	**$844.00**	$1,444.97	**$861.03**
Employee + 2 or More	$2,997.80	$1,969.00	**$1,028.80**	$1,878.41	**$1,119.39**
PPO Plans					
Anthem Blue Cross - 80/20 Plan PERS GOLD (Formerly PERS Select)					
Employee Only	$701.23	$889.00	**$0.00**	$875.00	**$0.00**
Employee + 1	$1,402.46	$1,462.00	**$0.00**	$1,444.97	**$0.00**
Employee + 2 or More	$1,823.20	$1,969.00	**$0.00**	$1,878.41	**$0.00**
Anthem Blue Cross - 90/10 Plan PERS PLATINUM (Formerly PERS Care/Choice)					
Employee Only	$1,057.01	$889.00	**$168.01**	$875.00	**$182.01**
Employee + 1	$2,114.02	$1,462.00	**$652.02**	$1,444.97	**$669.05**
Employee + 2 or More	$2,748.23	$1,969.00	**$779.23**	$1,878.41	**$869.82**

Cost Breakdown The rates below are effective January 1, 2022.

Note, other plans may be available depending on your zip code.

Use CalPERS Health Plan Search by zip code tool.

Coverage Level	Premium	Trustees		AFSCME (Facilities)	
		Portion Paid by District	Out of Pocket	Portion Paid by District	Out of Pocket
HMO Plans					
Anthem Blue Cross Traditional					
Employee Only	$1,304.00	$789.00	**$515.00**	$864.00	**$440.00**
Employee + 1	$2,608.00	$1,312.00	**$1,296.00**	$1,678.00	**$930.00**
Employee + 2 or More	$3,390.40	$1,717.00	**$1,673.40**	$2,166.00	**$1,224.40**
Anthem Blue Cross Select – Limited Network					
Employee Only	$1,015.81	$789.00	**$226.81**	$864.00	**$151.81**
Employee + 1	$2,031.62	$1,312.00	**$719.62**	$1,678.00	**$353.62**
Employee + 2 or More	$2,641.11	$1,717.00	**$924.11**	$2,166.00	**$475.11**
Blue Shield Access+					
Employee Only	$1,116.01	$789.00	**$327.01**	$864.00	**$252.01**
Employee + 1	$2,232.02	$1,312.00	**$920.02**	$1,678.00	**$554.02**
Employee + 2 or More	$2,901.63	$1,717.00	**$1,184.63**	$2,166.00	**$735.63**
Kaiser Permanente					
Employee Only	$857.06	$789.00	**$68.06**	$864.00	**$0.00**
Employee + 1	$1714.12	$1,312.00	**$402.12**	$1,678.00	**$36.12**
Employee + 2 or More	$2,228.36	$1,717.00	**$511.36**	$2,166.00	**$62.36**
HealthNet SmartCare					
Employee Only	$1,153.00	$789.00	**$364.00**	$864.00	**$289.00**
Employee + 1	$2,306.00	$1,312.00	**$994.00**	$1,678.00	**$628.00**
Employee + 2 or More	$2,997.80	$1,717.00	**$1,280.80**	$2,166.00	**$831.80**
PPO Plans					
Anthem Blue Cross - 80/20 Plan PERS GOLD (Formerly PERS Select)					
Employee Only	$701.23	$789.00	**$0.00**	$864.00	**$0.00**
Employee + 1	$1,402.46	$1,312.00	**$90.46**	$1,678.00	**$0.00**
Employee + 2 or More	$1,823.20	$1,717.00	**$106.20**	$2,166.00	**$0.00**
Anthem Blue Cross - 90/10 Plan PERS PLATINUM (Formerly PERS Care/Choice)					
Employee Only	$1,057.01	$789.00	**$268.01**	$864.00	**$193.01**
Employee + 1	$2,114.02	$1,312.00	**$802.02**	$1,678.00	**$436.02**
Employee + 2 or More	$2,748.23	$1,717.00	**$1,031.23**	$2,166.00	**$582.23**

Cost Breakdown The rates below are effective January 1, 2022.

Note, other plans may be available depending on your zip code.

Use CalPERS Health Plan Search by zip code tool.

Coverage Level	Premium	CSEA (Classified)		Classified Prof/Sups, Confidential	
		Portion Paid by District	Out of Pocket	Portion Paid by District	Out of Pocket
HMO Plans					
Anthem Blue Cross Traditional					
Employee Only	$1,304.00	$880.00	**$424.00**	$925.00	**$379.00**
Employee + 1	$2,608.00	$1,497.00	**$1,111.00**	$1,632.00	**$976.00**
Employee + 2 or More	$3,390.40	$1,939.39	**$1,451.01**	$2,184.00	**$1,206.40**
Anthem Blue Cross Select – Limited Network					
Employee Only	$1,015.81	$880.00	**$135.81**	$925.00	**$90.81**
Employee + 1	$2,031.62	$1,497.00	**$534.62**	$1,632.00	**$399.62**
Employee + 2 or More	$2,641.11	$1,939.39	**$701.72**	$2,184.00	**$457.11**
Blue Shield Access+					
Employee Only	$1,116.01	$880.00	**$236.01**	$925.00	**$191.01**
Employee + 1	$2,232.02	$1,497.00	**$735.02**	$1,632.00	**$600.02**
Employee + 2 or More	$2,901.63	$1,939.39	**$962.24**	$2,184.00	**$717.63**
Kaiser Permanente					
Employee Only	$857.06	$880.00	**$0.00**	$925.00	**$0.00**
Employee + 1	$1714.12	$1,497.00	**$217.12**	$1,632.00	**$82.12**
Employee + 2 or More	$2,228.36	$1,939.39	**$288.97**	$2,184.00	**$44.36**
HealthNet SmartCare					
Employee Only	$1,153.00	$880.00	**$273.00**	$925.00	**$228.00**
Employee + 1	$2,306.00	$1,497.00	**$809.00**	$1,632.00	**$674.00**
Employee + 2 or More	$2,997.80	$1,939.39	**$1,058.41**	$2,184.00	**$813.80**
PPO Plans					
Anthem Blue Cross - 80/20 Plan PERS GOLD (Formerly PERS Select)					
Employee Only	$701.23	$880.00	**$0.00**	$925.00	**$0.00**
Employee + 1	$1,402.46	$1,497.00	**$0.00**	$1,632.00	**$0.00**
Employee + 2 or More	$1,823.20	$1,939.39	**$0.00**	$2,184.00	**$0.00**
Anthem Blue Cross - 90/10 Plan PERS PLATINUM (Formerly PERS Care/Choice)					
Employee Only	$1,057.01	$880.00	**$177.01**	$925.00	**$132.01**
Employee + 1	$2,114.02	$1,497.00	**$617.02**	$1,632.00	**$482.02**
Employee + 2 or More	$2,748.23	$1,939.39	**$808.84**	$2,184.00	**$564.23**

Cost Breakdown The rates below are effective January 1, 2022.

Note, other plans may be available depending on your zip code.

Use CalPERS Health Plan Search by zip code tool.

Coverage Level	Premium	Classified Exempt Sups	
		Portion Paid by District	Out of Pocket
HMO Plans			
Anthem Blue Cross Traditional			
Employee Only	$1,304.00	$889.00	**$415.00**
Employee + 1	$2,608.00	$1,537.00	**$1,071.00**
Employee + 2 or More	$3,390.40	$2,067.00	**$1,323.40**
Anthem Blue Cross Select – Limited Network			
Employee Only	$1,015.81	$889.00	**$126.81**
Employee + 1	$2,031.62	$1,537.00	**$494.62**
Employee + 2 or More	$2,641.11	$2,067.00	**$574.11**
Blue Shield Access+			
Employee Only	$1,116.01	$889.00	**$227.01**
Employee + 1	$2,232.02	$1,537.00	**$695.02**
Employee + 2 or More	$2,901.63	$2,067.00	**$834.63**
Kaiser Permanente			
Employee Only	$857.06	$889.00	**$0.00**
Employee + 1	$1714.12	$1,537.00	**$177.12**
Employee + 2 or More	$2,228.36	$2,067.00	**$161.36**
HealthNet SmartCare			
Employee Only	$1,153.00	$889.00	**$264.00**
Employee + 1	$2,306.00	$1,537.00	**$769.00**
Employee + 2 or More	$2,997.80	$2,067.00	**$930.80**
PPO Plans			
Anthem Blue Cross - 80/20 Plan PERS GOLD (Formerly PERS Select)			
Employee Only	$701.23	$889.00	**$0.00**
Employee + 1	$1,402.46	$1,537.00	**$0.00**
Employee + 2 or More	$1,823.20	$2,067.00	**$0.00**
Anthem Blue Cross - 90/10 Plan PERS PLATINUM (Formerly PERS Care/Choice)			
Employee Only	$1,057.01	$889.00	**$168.01**
Employee + 1	$2,114.02	$1,537.00	**$577.02**
Employee + 2 or More	$2,748.23	$2,067.00	**$681.23**

Plan Highlights	Kaiser Permanente HMO	Health Net Smartcare HMO	Anthem Blue Cross Select, Traditional HMO & Access+
	In-network Only	**In-network Only**	**In-network Only**
Annual Calendar Year Deductible			
Individual	None	None	None
Family			
Maximum Calendar Year co-pay, excluding pharmacy			
Individual	$1,500	$1,500	$1,500
Family	$3,000	$3,000	$3,000
Lifetime Maximum			
Individual	Unlimited	Unlimited	Unlimited
Professional Services			
Primary Care Physician (PCP)	$15	$15	$15
Preventative Care Exam	No charge	No charge	No charge
Well-baby Care	No charge	No charge	No charge
Diagnostic X-ray and Lab	No charge	No charge	No charge
Hospital Services			
Inpatient	No charge	No charge	No charge
Outpatient Surgery	$15	No charge	No charge
Emergency Room (copay waived if admitted)	$50	$50	$50
Urgent Care	$15	$15	$15
Additional Services			
Chiropractic / Acupuncture (20 visits combined)	$15	$15	$15
Infertility	50% of covered charges	50% of covered charges	50% of covered charges
Skilled nursing facility care	No charge	No charge	No charge
Durable Medical Equipment (DME)	No charge	No charge	No charge
Retail Prescription Drugs	Up to 30 day supply	Up to 30 day supply	Up to 30 day supply
Prescription deductible	None	None	None
Generic	$5	$5	$5
Preferred	$20	$20	$20
Non-Preferred	-	$50	$50
Mail Order Prescription Drugs	Up to 100 day supply	Up to 90 day supply	Up to 90 day supply
Max co-payment per person	N/A	$1,000	$1,000
Generic	$10	$10	$10
Preferred	$40	$40	$40
Non-Preferred	-	$100	$100

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Plan Highlights	Anthem PERS GOLD PPO	
	In-network	**Out-of-network**
Annual Calendar Year Deductible		
Individual	$1,000 (1)	
Family	$2,000 (1)	
Coinsurance (amount you pay)	20%	40%
Maximum Calendar Year co-insurance, excluding pharmacy		
Individual	$3,000	None
Family	$6,000	
Lifetime Maximum		
Individual	None	
Professional Services		
Primary Care Physician (PCP)	$35 (1,2)	40%
Preventative Care Exam	No charge	40%
Diagnostic X-ray and Lab	20%	40%
Hospital Services		
Inpatient	20% (2)	40%
Outpatient Surgery	20% (2)	40%
Emergency Room (copay waived if admitted)	$50 deductible + 20%	
Urgent Care	$35	40%
Additional Services		
Chiropractic / Acupuncture (20 visits combined)	$15	40%
Infertility	Not covered	
Skilled nursing facility care	No charge	No charge
Durable Medical Equipment	20%	40%
Retail Prescription Drugs	**Up to 30 day supply**	
Prescription deductible	None	
Generic	$5	
Preferred	$20	
Non-Preferred	$50	
Retail after 2nd refill	**Up to 30 day supply**	
Generic	$10	
Preferred	$40	
Non-Preferred	$100	
Mail Order Prescription Drugs	**Up to 90 day supply**	
Max co-payment per person	$1,000	
Generic	$10	
Preferred	$40	
Non-Preferred	$100	

(1) Incentives available to reduce individual deductible (max. $500) or family deductible (max. $1,000) include: getting a biometric screening ($100 credit); receiving a flu shot ($100 credit); getting a non-smoking certification ($100 credit); getting a virtual second opinion ($100 credit); and getting a condition care certification ($100 credit).
(2) Coinsurance waived for deliveries if enrolled in Future Moms Program.
The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations ahsa d exclusions.

Plan Highlights	Anthem PERS Platinum	
	In-network	**Out-of-network**
Annual Calendar Year Deductible		
Individual	$500	
Family	$1,000	
Coinsurance (amount you pay)	10%	40%
Maximum Calendar Year co-insurance, excluding pharmacy		
Individual	$2,000	None
Family	$4,000	
Lifetime Maximum		
Individual	None	
Professional Services		
Primary Care Physician (PCP)	$20 (2)	40%
Preventative Care Exam	No charge	40%
Diagnostic X-ray and Lab	10%	40%
Hospital Services		
Inpatient	$250 deductible + 10%	$250 deductible + 40%
Outpatient Surgery	$250 deductible + 10%	$250 deductible + 40%
Emergency Room (copay waived if admitted)	$50 deductible + 10%	
Urgent Care	$35	40%
Additional Services		
Chiropractic / Acupuncture (20 visits combined)	$15	40%
Infertility	Not covered	
Skilled nursing facility care	No charge	No charge
Durable Medical Equipment	10%	40%
Retail Prescription Drugs	**Up to 30 day supply**	
Generic	$5	
Preferred	$20	
Non-Preferred	$50	
Retail after 2nd refill	**Up to 30 day supply**	
Generic	$10	
Preferred	$40	
Non-Preferred	$100	
Mail Order Prescription Drugs	**Up to 90 day supply**	
Max co-payment per person	$1,000	
Generic	$10	
Preferred	$40	
Non-Preferred	$100	

(2) Coinsurance waived for deliveries if enrolled in Future Moms Program.
The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Prescription Drug Coverage with OptumRx

Many FDA-approved prescription medications are covered through the benefits program. OptumRx acts as the Pharmacy Benefit Manager for a majority of CalPERS health plans, other than Kaiser. Important information regarding your prescription drug coverage is outlined below:

- The medical plans covers generic formulary, brand-name formulary, and non-formulary brand
- Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts
- A brand-name medication is protected by a patent and can only be produced by one specified manufacturer
- Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list
- Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring

WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:

Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90 or 100-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.

For more information visit https://www.optumrx.com/oe_calpers/landing

TIP

Medical Services Covered in Full

The federal Health Care Reform law now requires insurance companies to cover preventive care services in full, saving you money and helping you maintain your health. Preventive services may include annual check-ups, well-baby and child visits and certain immunizations and screenings.

To confirm that your preventive care services are covered, refer to your plan documents.

Workplace Wellness

Why Wellness?

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. We care about your total well-being, and encourage all employees to engage in our Wellness Program at no-cost.

Healthy Lifestyles Program

Kaiser Permanente invites you to take an active role in improving your health with free, customized online programs designed to help you succeed in creating a healthier lifestyle. These programs are brought to you in collaboration with HealthMedia®, and focus on your total health—mind, body, and spirit. Fill out the online questionnaire at kp.org/healthylifestyles and receive your customized guide to a program that may include:

- **Smoking cessation:** Create a plan that will support you in quitting for good!
- **Nutrition:** Nutrition plans that are customized for your lifestyle and may correct food choices that can improve or sustain your health and well-being
- **Sleep:** Changing the way you think about sleep can increase your much needed shut eye
- **Stress:** Work on your individual stress triggers and develop a stress reduction plan that works for you

Decision Power

With a long-term investment in the health of your organization, Health Net's *Decision Power* is the bridge to well-being action. Log onto www.healthnet.com to take your Health Risk Questionnaire and receive a personalized action plan. You will find tools to help you with:

- **Tobacco Cessation:** Comprehensive tobacco program with telephonic and online support
- **Health Coaching:** Online health coaching and resources to enhance your well-being experience and provide additional support
- **Healthy Living Programs:** Information and tools to improve your health and reduce risk of disease
- **Online seminars:** Fun and engaging seminars, giving you the opportunity to learn about important health topics

Wellbeing Solutions

Your whole health matters. That's why you have Wellbeing Solutions, a suite of programs to help you with your everyday health and cover all areas of your well-being. Personalized information, 24/7 access to a nurse, and trained health management professionals are all available to help you navigate the health care system and use your benefits wisely. Plus, it's part of your plan at no extra cost. Navigating your health can be challenging at times, but at Anthem everything is at your fingertips. Staying on top of your health easy with Sydney, our fully integrated digital platform that helps you find everything you need to know about your Anthem benefits -- personalized and all in one place.

Start today by visiting www.anthem.com/ca or download the Sydney Health app from the App Store or Google Play.

Benefits Information on the Go

Kaiser Permanente – On the Go!

The KP mobile app gives you a suite of tools to use on the go! Use this application with your Kaiser Permanente user ID and password to:

- See your health history at your fingertips
- Refill prescriptions for yourself or another member
- Check the status of your prescription order
- Schedule, view, and cancel appointments
- Access your message center to email your doctor or another KP department
- Find KP locations and facilities near you

Register on www.kp.org/calpers and search for Kaiser's mobile app in the App Store or Google Play to get started!

Anthem – On the Go!

With Anthem's mobile app, you can:

- Find a doctor, hospital or urgent care facility
- Login to view your personal benefits information
- Fax or email your Mobile ID card from your smartphone or device directly to your doctor
- Contact Anthem Customer Support directly from the app

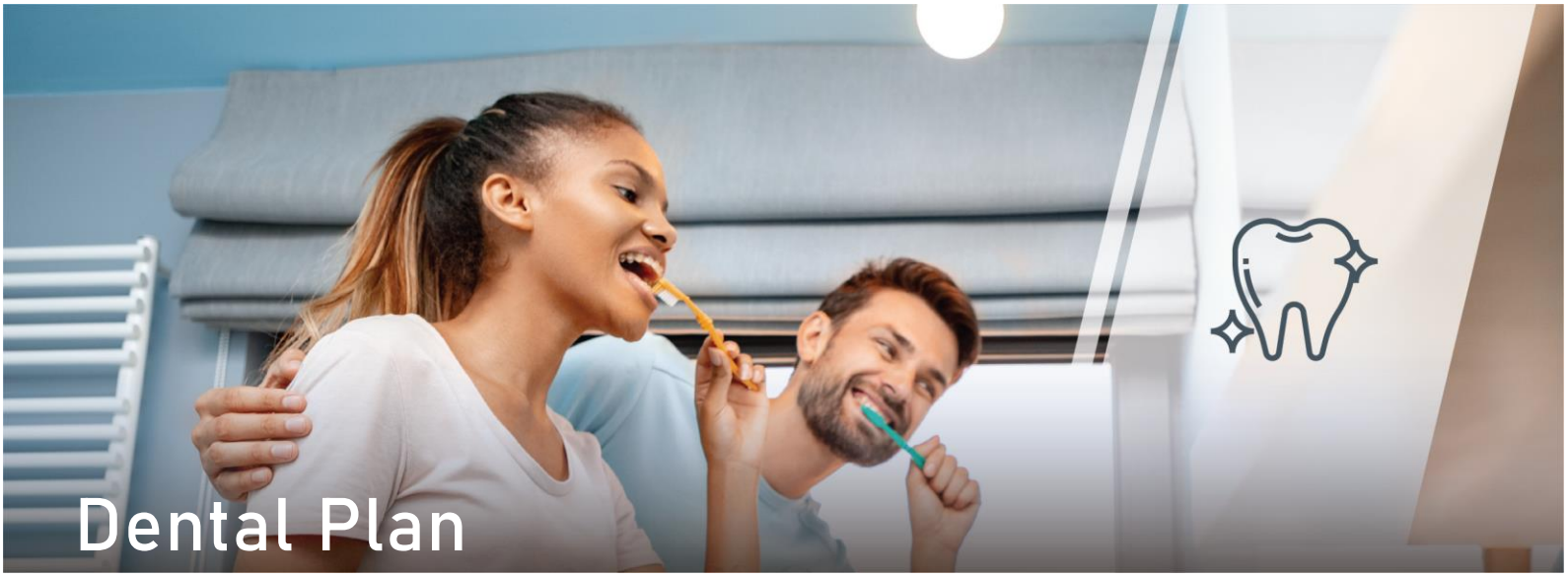
Register on www.anthem.com/ca/calpers and search for Anthem's mobile app in the App Store or Google Play to get started!

Health Net – On the Go!

Health Net Mobile is the easiest way to connect to a HealthNet.com online account and is designed to help you on the go. Use this application to:

- Quickly get plan, copay, and deductible information
- Access your Mobile ID card to verify eligibility
- Review plan details
- Search provider information
- View Health Net contact information

Register on www.healthnet.com/calpers and search for Health Net's mobile app in the App Store or Google Play to get started!



Dental Plan

At no cost to you or your eligible dependent(s), choose from two comprehensive dental plans for you and your eligible dependent(s).

DeltaCare Plan

- Must receive all dental care services from a dentist who participates in the DeltaCare 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.
- Plan includes orthodontic care; services must be provided by a DeltaCare orthodontist.

Delta Dental Plan PPO

- Flexibility to seek dental care services from any dentist, in or out of network.
- Receive the most savings by seeing a Delta Dental PPO Network Provider or a Delta Dental Premier Network Provider.
- Responsible for paying any charges over Delta Dental's approved fees when out-of-network.

Visit the Delta Dental Website at www.deltadentalins.com

- Download a digital card, view your benefits, covered dependent(s), claims and more!

Plan Highlights	DeltaCare	Delta Dental PPO	
	In-Network Only	In-Network	Out-of-Network
Calendar Year Deductible			
Individual / Family	None	None	
Cleanings Per Year	2 (1 per 6-month period)	3 (per year)	
Annual Maximum (In-Network & Out-of-Network Maximums are not combined)	None	$2,200 per person	$2,000 per person
Preventive and Diagnostic	$5 - $45 Copay, *See Schedule of Benefits*	Covered 100%	Covered at 70% - 100% of contracted fees (1)
Basic Services	See Schedule of Benefits	Covered 100%	Covered at 70% - 100% of contracted fees (1)
Jackets, crown restoration	$35 - $195 Copay, *See Schedule of Benefits*	Covered 100%	Covered at 70% - 100% of contracted fees (1)
Prosthodontics	$5 - $170 Copay, See Schedule of Benefits	Covered at 50% at contracted fees	
Dental Accidents Benefit	See Schedule of Benefits	Covered at 100% with a separate maximum at $1,000 per person per calendar year	
Orthodontic Care	$25 – $1,900 Copay, *See Schedule of Benefits*	Not covered	

(1) 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.

The above information is a summary only. Please refer to your Schedule of Benefits and Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Vision Plan

At no cost to you or your eligible dependent(s) you can enroll in the VSP Preferred Provider Organization (PPO) plan.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

Eyeconic Online

Eyeconic is the only online retailer where you can buy glasses, sunglasses, and contacts with your VSP benefits. Visit www.eyeconic.com today to learn more.

To view a complete plan summary, visit www.vsp.com.

Plan Highlights	VSP Vision PPO	
	In-Network	**Out-of-Network**
Exam – Every 12 months	$10	$10
Single	Paid in full	$45 maximum benefit
Bifocal	Paid in full	$65 maximum benefit
Trifocal	Paid in full	$85 maximum benefit
Frames – Every 12 months	Covered up to $130 plus 20% off any out-of-pocket expenses	Covered up to $50
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	Paid in full	$210 maximum benefit
Cosmetic	Covered up to $105	Covered up to $105

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

TIP

Five Tips for Superior Vision

Don't take your eyes for granted! The following pointers can help you keep your vision strong:

- **Eat lots of leafy greens and dark berries**
- **Get regular eye exams**
- **Give your eyes a rest from staring into the computer screen**
- **Wear sunglasses to protect your eyes from bright light**
- **Wear safety eyewear whenever necessary**

Life and Disability

Basic Life and AD&D

Protect your loved ones

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Your coverage

Paid for in full by SMCCCD, the benefits outlined below are provided by Guardian:

- Certificated or Classified employees receive Basic Life Insurance and AD&D of 1x annual salary up to $100,000
- Administrator or Trustee employees receive Basic Life Insurance and AD&D of 2x annual salary up to $1,000,000

Dependent Coverage

Paid for in full by SMCCCD, the benefits outlined below are provided by Guardian:

- Your spouse/domestic partner and dependent children ages 14 days to 26 years old, are eligible for Basic Life Insurance coverage in the amount of $1,500.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated**
- **To select or change your beneficiary contact Human Resources**

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase on a payroll deduction basis through Guardian.

- **For employees:** Increments of $10,000 up to a $500,000 maximum with a guarantee issue benefit of $100,000 if you enroll in the plan within 30 days of your initial eligibility
- **For your spouse:** Increments of $5,000 up to the lesser of 50% of the employee's benefit or a $250,000 maximum with a guarantee issue benefit of $25,000 if you enroll in the plan within 30 days of your initial eligibility
- **For your child(ren):** 6 months and up, Increments of $2,000 up to $10,000;

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Refer to the Voluntary Life Premium Rate Sheet on the district downloads or contact HR for rates.

Short & Long Term Disability

Added protection

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Short Term Disability (STD)	• Administered by Guardian, STD coverage provides a benefit equal to 66.66% of your earnings, up to $3,500 per week for a period up to 22 weeks • The plan begins paying these benefits after you have been absent from work for 30 consecutive days
Long Term Disability Coverage (LTD)	• If your disability extends beyond 22 weeks, the LTD coverage through Guardian can replace 66.66% of your earnings • Classified and Certificated employees with less than 5 years of credit with CALSTRS will receive 66.66% to a maximum of $5,000 per month till social security normal retirement age, as defined in the plan documents • Certificated employees with 5 years or more of credit with CALSTRS will receive 66.66% to a maximum of $5,000 per month for 2 years or to age 70 whichever occurs first • Administrators will receive 66.66% to a maximum of $15,000 per month till social security normal retirement age, as defined in the plan documents • For benefit information for classified employees over the age of 63, or certificated employees over the age of 66, contact Human Resources

Please note: SMCCCD does not contribute to California State Disability. For more information please contact human resources.

TIP

Disability Facts and Figures

- **One in every 8 people will become disabled for five years or more in their lifetime**
- **30% of people use disability coverage**
- **Nearly half (46%) of all foreclosures are caused by financial hardship due to a disability**

Source: www.affordableinsuranceprotection.com/disability_facts

Tax considerations

Because disability coverage is an employer-paid benefit and is available for employees at no cost, any disability payments made to you will be taxable.

Please note: Consult your tax advisor for additional taxation information or advice.

Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care, dependent care, and transit/parking expenses. There are a number of different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse and eligible dependents, as outlined below:

FSA Type	Detail
Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • **Maximum contribution for 2022 is $2,850.**
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) child care expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • **Maximum contribution for 2022 is $5,000.**
Commuter Spending Account	• Can be used to cover qualified transit passes, vanpooling, payments for transportation in a commuter highway vehicle, and qualified parking costs. • Parking maximum contribution for 2022 is $270 per month. • Transit maximum contribution for 2022 is $270 per month. • Cash reimbursement is not allowed. You must use the FSA Debit card for all parking and transit purchases.

What are the benefits?

- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

How do I use it?

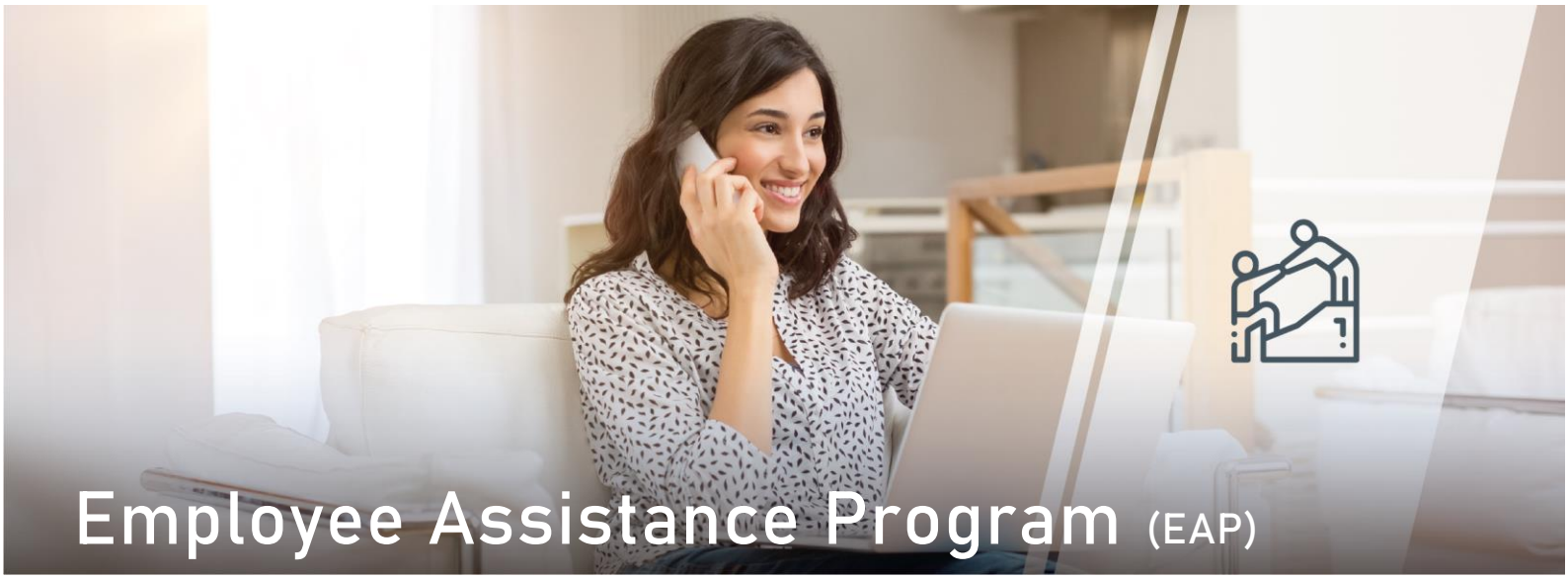
You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status and more.

- **Visit** https://www.payflex.com to access PayFlex's online portal.

A few rules you need to know:

- The amount you decide to contribute will be locked from January 1 to December 31 unless you have a qualifying life event
- Although the FSA plan year runs from January 1, 2022 through December 31, 2022, the plan allows a grace period through March 15, 2023 allowing you to incur expenses 2 ½ months after the plan year ends
- You have until March 31, 2023 to submit any claims for reimbursement. If you don't submit claims by then, they will not be reimbursed. This is called the Run-out Period
- Keep in mind that the IRS prohibits you from using these accounts to reimburse expenses incurred by domestic partners or their children

For more details about using an FSA, contact Human Resources.



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.

Program Component	Coverage Details
Who Can Utilize	All employees, dependents of employees, and members of your household
Topics May Include	• Childcare • Eldercare • Legal services • Identity theft • Marital, relationship or family problems • Bereavement or grief counseling • Substance abuse and recovery • Financial support • Consumer information
Number of Sessions	3 face-to-face sessions per issue per 12 months for more serious concerns

TIP

How to Access:

- **By Phone: 800.834.3773**
- **Online: www.claremonteap.com**

Retirement Options

California Public Employees' Retirement System (CalPERS)

Defined Benefit

CalPERS offers a "defined benefit" plan which provides benefits that are calculated using a "defined formula," rather than contributions and earnings to a savings plan.

Retirement benefits are calculated using:

- a member's years of service credit
- age at retirement
- final compensation

2% at age 55 Benefit Formula

Your benefit factor is the percentage of pay to which you are entitled for each year of service. It is determined by your age at retirement and the retirement formula for our District, which is 2% at age 55.

Your final compensation is the highest average pay rate during any consecutive one year period.

Eligibility for service retirement:

- at least age 50 **and**
- minimum of five years of CalPERS credited service

Contribution Rates:

- employees contribute 7% of their creditable compensation
- employers contribute 22.910% of employee's creditable compensation

Employer contributions are not credited to your account but are deposited in the Public Employees' Retirement fund to help fund the benefits payable to all members and beneficiaries.

2% at age 62 Benefit Formula (Membership date on or after January 1, 2013)

Your benefit factor is the percentage of pay to which you are entitled for each year of service. It is determined by your age at retirement and the retirement formula for our District, which is 2% at age 62.

Your final compensation is the highest average pay rate during any consecutive three-year period.

**There is a cap on the compensation used to calculate your benefit. Please see CalPERS Member Handbook for details.*

Eligibility for service retirement:

- at least age 52 and
- have a minimum of five years of CalPERS credited service

Contribution Rates:

- employees contribute 8% of their creditable compensation
- employers contribute 25.37% of employee's creditable compensation

Employer contributions are not credited to your account but are deposited in the Public Employees' Retirement fund to help fund the benefits payable to all members and beneficiaries.

California State Teachers' Retirement System (CalSTRS)

Defined Benefit

CalSTRS offers a "defined benefit" plan which provides benefits that are calculated using a "defined formula," rather than contributions and earnings to a savings plan.

Retirement benefits are calculated using:

- member's years of service credit
- age at retirement
- final compensation

2% at age 60 Benefit Formula

Your benefit factor is the percentage of pay to which you are entitled for each year of service. It is determined by your age at retirement and the retirement formula for our District, which is 2% at age 60.

Eligibility for service retirement:

- five years of service credit under the Defined Benefit Program
- at least age 50 if you have at least 30 years of service credit
- age 55 with at least five years of service credit

Contribution Rates:

- employees contribute 10.25% of their creditable compensation
- employers contribute 19.10% of employee's creditable compensation

Employer contributions are not credited to your account but are deposited in the State Teachers' Retirement fund to help fund the benefits payable to all members and beneficiaries.

2% at age 62 Benefit Formula (Membership date on or after January 1, 2013)

Your benefit factor is the percentage of pay to which you are entitled for each year of service. It is determined by your age at retirement and the retirement formula for our District, which is 2% at age 62.

**There is a cap on the compensation used to calculate your benefit. Please see CalSTRS Member Handbook for details.*

Eligibility for service retirement:

- five years of service credit under the Defined Benefit Program
- at least age 55 with at least five years of service credit

Contribution Rates:

- employees contribute 10.205% of their creditable compensation
- employers contribute 19.10% of employee's creditable compensation

Employer contributions are not credited to your account but are deposited in the State Teachers' Retirement fund to help fund the benefits payable to all members and beneficiaries.

TIP

How to Access:

- **Online:**
  www.my.calpers.ca.gov or
  www.my.calstrs.com

Other Retirement Savings Options

403(b) and 457 Plans

The District offers these two tax-sheltered retirement plans. Both plans allow employees to make pretax contributions for retirement purposes into investment products that fall under mutual funds, variable annuities or fixed annuities. Earnings in these plans grow tax-deferred.

For a complete list of approved vendors and contact information, please reference the list below or go to our Human Resources folder on the Downloads page.

Please visit www.403bcompare.com for 403(b) plan fees, charges, expense and other costs to employees.

Contribution Limits:

- For 2022 the IRS annual contribution limits are $20,500 for everyone under age 50
- Catch up limit for anyone that is age 50 or over prior to December 31, 2022 is $27,000.

Enroll anytime throughout the year.

How to Enroll?

1. Establish an account with one of the approved vendors by contacting them directly
2. Obtain an account number
3. Download and complete the applicable 403(b) and 457 form. (link to forms below)
4. Submit the 403(b) and 457 form to the following District Payroll personnel:
    a. Sharon Himebrook – Faculty
    b. Christopher Luo – Administrators and Classified

When will it be effective?

- 403(b) plan - effective the 1st of the *current* month if submitted by the 15th; otherwise 1st of the *following* month.
- 457 plan - effective 1st of the following month from when it is received.

Approved Vendors

Vendor	Contribution Forms	Contact Number
CalSTRS Pension II Program (VOYA Financial) – 403(b) Plan	403(b) Salary Reduction Form	(415) 882-3667
CalSTRS Pension II Program (VOYA Financial) – 457 Plan	CalSTRS Pension II 457 Plan Contribution Form	(888) 394-2060
FIDELITY SERVICE COMPANY - 403(b)	403(b) Salary Reduction Form	(800) 328-6608
FRANKLIN TEMPLETON Bank & Trust, FSB - 403(b)	403(b) Salary Reduction Form	(800) 527-2020
GREAT AMERICAN FINANCIAL RESOURCES, INC. - 403(b)	403(b) Salary Reduction Form	(800) 789-6771
EMPOWER (formerly Mass Mutual) 457 Plan	EMPOWER 457 Contribution Form	(650) 583-8815
LIFE INSURANCE OF THE SOUTHWEST - 403(b)	403(b) Salary Reduction Form	(800) 579-2878
METROPOLITAN LIFE INSURANCE COMPANY (METLIFE) - 403(b)	403(b) Salary Reduction Form	(650) 274-1756
VALIC 403(b) & 457 Plan	VALIC 403(b) & 457 Plan Contribution Form	(650) 922-2031

Please note: SMCCCD does not endorse or assume any responsibility for these vendors. Consult your own tax advisor or representative of these vendors if you are interested in a TSA program.

Even More Benefits

CAÑADA COLLEGE | COLLEGE OF SAN MATEO
ATHLETIC CENTER

Cañada College and College of San Mateo Athletic Centers are managed by Community Fitness, a division of the San Mateo Community College District. A variety of health, fitness and wellness activities are available at state-of-the-art athletic centers. New employees can choose to join one or both locations and may include a partner or family in the discounted employee membership selection choice.

Designed to the primacy of the students, and housed cohesively with Kinesiology, Athletics and Dance departments, the Athletic Center members consist of students, faculty, staff and also the residents from the surrounding communities. A large choice of available fitness options includes: Extensive strength and cardio-vascular training equipment, aquatics, group exercise classes, community education, adaptive fitness and pickle-ball courts, depending on the location. The mission of the Athletic Centers is to create a connection between community and education.

Please contact Cañada College Athletic Center at: 650.381.7375 or College of San Mateo Athletic Center a: 650.378.7373 to learn more or email sanmateoac@smccd.edu.

Financial Wellness

Financial wellness is an important part of your overall health and wellness. To support you, SMCCD offers a variety of financial courses plus we partner with local credit unions that provide special offers for SMCCD employees.

Look for financial courses offered at the District as well as the Credit union branch locations on a variety of topics, including:

- Basics of Personal Finance
- 10 Steps to Financial Success
- Paying for Higher Education
- Purchasing a Home in Today's Competitive Market
- First-Time Home Buying
- Creating a Budget
- Safeguarding Against Identity Theft

In addition, the following credit unions offer special programs and savings for SMCCD employees

Provident Credit Union

- **Special Offer**: Provident Credit Union is offering free checking accounts with a 300 dollar bonus and a relationship pricing discount of 0.125% off Mortgages and Auto loans. Contact Art Pimentel, Account Executive, at (650) 801-7143, apimentel@providentcu.org, or online at http://www.providentcu.org/SMCCD to learn more

San Mateo Credit Union

- **Special Offer**: San Mateo Credit Union offers SMCCCD employees exclusive benefits including a $50 new checking bonus, up to $600 credit on mortgage appraisal fees, and more! Visit the SMCCCD employees benefits page to learn more www.smcu.org/SMCCCD or contact your benefits representatives at communityrelations@smcu.org

Technology Credit Union (TechCU)

- **Special Offer**: Get up to $150 for opening a new checking account with direct deposit and bill pay. This account offers free checking, with non-minimum balance, and free access to more than 65,000 ATMs plus exclusive benefits and discounts. Contact Cathy Caday, Palo Alto Branch Manager, at 408.306.2202, or ccaday@techcu.com to learn more

TicketsatWork.com
Fun. With benefits.

Welcome to the TicketsatWork benefits program, our provider for discounts to theme parks, attractions and shows nationwide. Through TicketsatWork, you will receive discounts and special access to theme parks and attractions as well as savings on car rentals, hotels, tours and attractions across the US. Call customer service at 800.331.6483 or visit www.ticketsatwork.com, click on "Become a Member", then create an account with your email address and the company code: SMCCCD

Have the season's best selection of fresh, organic produce and natural grocery items delivered right to your door! Visit www.farmfreshtoyou.com for more information. Use promo code SMCCCD for 10% off.

Directory & Resources

Below, please find important contact information and resources for SMCCCD.

Information Regarding	Contact Information	
Enrollment & Eligibility		
Human Resources: Jessica Esclamado Noemi Diaz David Feune	 650.358.6827 650.358.6844 650.358.6775	 esclamadodavidj@smccd.edu diazn@smccd.edu feune@smccd.edu
Medical Coverage		
Anthem Blue Cross HMO Anthem PER Platinum, PERS Gold Blue Shield Access+ Health Net HMO Kaiser Permanente HMO	855.839.4524 877.737.7776 800.334.5487 888.926.4921 800.464.4000	www.anthem.com/ca/calpers www.anthem.com/ca/calpers https://myoptions.blueshieldca.com/calpers www.healthnet.com/calpers www.kp.org/calpers
Prescription Coverage		
OptumRx Kaiser Permanente	855.505.8110 800.464.4000	www.optumrx.com/calpers www.kp.org/calpers
Dental Coverage		
Delta Dental DeltaCare	800.765.6003 800.422.4234	www.deltadentalins.com
Vision Coverage		
VSP Vision	800.877.7195	www.vsp.com
Life, AD&D and Disability		
Guardian Life Insurance and AD&D Guardian Short and Long Term Disability	800.525.4542 Short Term: 800.268.2525 Long Term: 800.538.4583	www.guardiananytime.com
Flexible Spending Accounts		
PayFlex Flexible Spending Account	844.729.3539	https://www.payflex.com
Employee Assistance Plan		
Claremont Employee Assistance Program	800.834.3773	www.claremonteap.com
Travel Assistance		
PayFlex Commuter Benefits	844.729.3539	https://www.payflex.com
Pension Plans		
CalPERS CalSTRS	888.225.7377 800.228.5453	www.calpers.ca.gov www.calstrs.com

For More Information

To learn more about a benefit or download benefit forms, visit the Human Resources section of the SMCCCD Portal Site:

- Go to www.smccd.edu/portal
- Click District Downloads
- Click on Human Resources

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

Medicare Part D notice

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, 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 to December 7. 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 prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

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 your employer and don't join a Medicare prescription 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 October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription 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)**

Legal Information Regarding Your Plans

REQUIRED NOTICES

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits 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.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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.

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage [(1)]
- Acquisition of a new spouse or dependent through marriage [(1)], adoption [(1)], placement for adoption [(1)] or birth [(1)]
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) [(1)]
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

- You do not need prior authorization from your insurance provider 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 our 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 your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered then the following will apply. 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 health 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.

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

(1) Indicates that this event is also a qualified "Change in Status"
(2) Indicates this event is also a HIPAA Special Enrollment Right
(3) Indicates that this event is also a COBRA Qualifying Event

CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: [Enter name of appropriate party].

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period [1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Jessica Esclamado-David
Human Resources Representative
3401 CSM Drive, San Mateo, CA 94402
650-358-6827
esclamadodavidj@smccd.edu

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [1]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [2]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [3], and if at least 50 employees are employed by the employer within 75 miles.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.
[2] The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"
[3] Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627 www.wagehour.dol.gov

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is EFFECTIVE: 1/1/2021

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- **Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.**
- **Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.**
- **Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.**
- **Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.**
- **Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.**

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- **Maintain the privacy and security of your health information.**
- **Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**
- **Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.**
- **Abide by the terms of this notice.**
- **Notify you if we are unable to agree to a requested restriction, amendment or other request.**
- **Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).**
- **Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.**

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

San Mateo County Community College District
Attention: David Feune
Director of Human Resources
3401 CSM Drive
San Mateo, CA 94402
650-358-6775

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, 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, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

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 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

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