

2011-2012

**Employee
BENEFITS
Guide**

Improving Your Quality Of Life



Contact Information

Below is a listing of the toll-free numbers you can call with questions about benefit coverage, transition of care, and providers in your area. You can also use the websites to access provider information as well as additional discount programs through each carrier.

Don't forget: By visiting our website at www.sbccd.org or www.benefitbridge.com/sbccd, you can access carrier information and forms for the benefit plans offered by the District.

For questions about...	Call...	Visit the web...
<u>Chiropractic Benefits</u>		
American Specialty Health	877-430-8092	www.ashcompanies.com
<u>Dental Benefits</u>		
DeltaCare Dental	800-422-4234	www.deltadentalins.com
Delta Dental PPO	866-499-3001	www.deltadentalins.com
<u>Employee Assistance Program</u>		
ACI Specialty Benefits	800-932-0034	www.acispecialtybenefits.com
<u>Flexible Spending</u>		
American Fidelity	800-365-9180	www.afadvantage.com
<u>Life Benefits</u>		
Prudential Life	800-631-0311	www.prudential.com
<u>Medical Benefits</u>		
Blue Cross HMO/PPO	800-888-8288	www.anthem.com/ca
Blue Cross Nurseline	800-977-0027	
Mail Order Pharmacy	800-369-0675	
Kaiser California	800-464-4000	www.kaiserpermanente
Mail Order Pharmacy	866-523-6059	www.members.kp.org
<u>Vision Benefits</u>		
MES Vision	800-877-6372	www.mesvision.org
Kaiser Vision	800-464-4000	www.kp2020.org
<u>Additional Assistance</u>		
Keenan & Associates	800-654-8347 Ext.1163 or 1156	www.benefitbridge.com/sbccd

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About this Guide

This Benefits Guide describes the highlights of the San Bernardino Community College District Benefits Program in non-technical language. Your specific rights to benefits under this program are governed solely by each carrier's Evidence of Coverage (EOC) and not the information contained within this Benefits Guidebook.

If there is any discrepancy between the descriptions of the program elements as contained within this Benefits Guidebook or other benefits enrollment materials you receive and the EOC, the EOC shall prevail. Please refer to the plan-specific documents published by the respective carriers for detailed plan information. Eligibility for any benefit plan is determined by applicable plan documents and policies. You should be aware that any elements of the San Bernardino Community College District Program may be modified in the future to meet Internal Revenue Service rules or otherwise as determined by the District.

Your 2011-2012 Benefits as a New Hire

As a new hire, it is now time to make your benefit choices for the remainder of the 2011-2012 plan year. We know that benefits are an important part of your total compensation, providing important protections and significant value to you and your family. This is your chance to make the most of the benefit options available to you. In this guide to your 2011-2012 benefits, you will see a summary of all benefits offered by the District for the upcoming fiscal year. As we move forward, each of us will need to take a more active role in managing our health care and other benefits. The District is committed to giving you the information and educational tools you need to make informed decisions about your benefits.

San Bernardino Community College District offers you a comprehensive and competitive program of benefits for you and your family. It is important that you:

- Consider your family's needs;
- Compare the costs of each benefit option; and
- Make your decisions and complete your enrollment by the deadline.

Please spend a few minutes to review this guide for the latest information about your 2011-2012 benefits. These materials will help you make informed decisions about your enrollment. **All benefit elections made as a New Hire will be effective the first of the month following your date of hire**

How do I Enroll in Benefits?

- You must complete the enrollment forms provided to you during orientation and return them no later than the first Friday following your hire date when you meet with American Fidelity.

What will happen when I meet with American Fidelity?

- You will prove eligibility for any dependents you want to add to your plan.
- You may sign up to participate in the Health Care Spending Account or Dependent Day Care Spending Account for 2011-2012.
- You may enroll in a voluntary Disability, Cancer and/or Accident Plan.
- Finally, they will ensure your forms are all complete and ready to be processed for your Health Benefits.

What happens if I DO NOT complete the Enrollment Process?

If you do not complete the enrollment process by the deadline, *you will not have coverage for the 2011-2012 fiscal year.*

Do I have to meet with American Fidelity this year?

Yes! If:

- You wish to participate in the Health Care or Dependent Day Care Spending Account for 2011-2012.
- You wish to enroll or make changes to your Disability, Cancer, or Accident Plans.

Can I waive coverage?

Yes!

- If you show proof of your other medical coverage, you can elect to opt-out of medical benefits.
- You must complete a Benefits Waiver form to make this election and provide proof of other medical coverage for you and your family.

Your Benefit Choices at a Glance

The District offers several benefit packages with choices and flexibility to help you meet your changing needs. Coverage in basic life insurance is provided automatically at \$30,000 per eligible employee as well as family coverage in the Employee Assistance Program. For the 2011-2012 fiscal year, your benefit options include:

- Medical, Vision and Chiropractic
- Dental
- Supplemental Life, Spousal Life and Dependent Child Life
- Flexible Spending Accounts (both Health Care and Dependent Day Care)

Eligibility for Coverage

To be eligible for coverage, you must be employed a minimum of 20 hours per week for Classified Employees, or a minimum of 35 hours per week for Academic Employees

Your eligible dependents for coverage include:

- Your legally married spouse or registered domestic partner.
- Dependent children (child, step child, adopted child, and recognized natural child) from birth through the 26th birthday.
- Fully disabled children defined as (a) incapable of self-sustaining employment by reason of mental or physical handicap and (b) chiefly dependent upon the eligible employee for economic support and maintenance.
- Legal guardianship with court filed documents (must be shown as a dependent on most recent federal income tax return).

During a benefits audit, initial enrollment or when requested, you must provide proof of dependent eligibility based on the above requirements. If proof of eligibility is not received within 30 days from the date of the request, **your dependent will be removed from your policy immediately.**

Qualifying Events

The benefits you choose when first eligible or during Open Enrollment must remain in effect for the full plan year unless you have a qualifying status change as defined by the IRS. Examples of qualified status changes are marriage, divorce, registration of domestic partner, birth or adoption of a child, death of a dependent, change in your or your spouse's job status and loss of dependent status. Changes to your benefits plan following a qualifying event, are subject to additional rules and regulations.

You are responsible for informing Human Resources of any changes in dependent status within 60 days of the event. Failure to do so will result in no coverage for your eligible dependent(s)/spouse until the next open enrollment period or may forfeit COBRA rights. Notification forms can be found at www.sbccd.org.

What is the Right Choice for You?

Be sure to compare your medical and dental choices carefully and select the plan that best meets your family's needs. The plans differ in the following ways:

- How much you have to pay out of your own pocket when you receive care;
- Your premium (your cost for coverage, which you pay through pre-tax and after-tax payroll deduction);
- Covered expenses and exclusions: the plans cover the same expenses, but at different levels;
- Whether the plan provides coverage for out of network providers.

Your Medical, Vision and Chiropractic Plan Choices

For the 2011-2012 fiscal year, you may choose one of the following medical plan options:

- Anthem Blue Cross HMO Low or High Copay
- Anthem Blue Cross PPO; or
- Kaiser California Low or High Copay

Each plan provides coverage for a variety of health care services and supplies, including preventive care, inpatient and outpatient services, and prescription drugs. The difference is how the plans pay benefits for this care. The charts on pages 12 and 13 compare the coverage under each plan for the different types of services.

Key Features of the Anthem BlueCross HMO Plan:

- You must choose a *Primary Care Physician* to coordinate your medical care needs;
- You do not have out-of-network coverage. This means that if your physician or hospital stops participating in the network mid-year, the plan will not pay for services with a non-participating provider and you will not be allowed to change plans;
- 360°Health provides many plans and services that help you get health, stay healthy, and live better. Plans include personalized online access, special offers, 24/7 NurseLine and more.
- Includes MES Vision and ASH Chiropractic Coverage.
- Anthem Blue Cross HMO \$20 co-pay and Anthem Blue Cross HMO \$40 co-pay allows you to choose whether or not you want to pay higher copayments or higher monthly premiums.

If you enroll in the Anthem Blue Cross HMO, you (and each of your enrolled dependents) must choose a personal physician to be your primary health care provider (PCP). Your PCP must be in the Anthem Blue Cross HMO network and belong to one of these groups: family practice, general practice, internal medicine, obstetrics/gynecology, or pediatrics.

Your PCP will coordinate all of your medical care. You and your dependents may each have your own personal physician, and you may change your personal physician whenever you wish by contacting Blue Cross by phone or one the website. Changes made by the 15th of the month will be effective the 1st of the following month.

Generally, you need to get a referral from your personal physician before you can go to a specialist. Under the Anthem Blue Cross HMO, there are several exceptions to this rule:

- No matter what medical group you are enrolled in, women may go directly to a gynecologist or family practice physician in their personal physician's medical group or practice association without a referral for your well woman examination.
- Your medical group may participate in the Direct Access program. Direct Access allows you to self-refer to three types of specialists; allergists, dermatologists, and ear, nose, and throat (ENT) specialists who belong to your medical group.
- Speedy Referral allows your physician to refer you to 16 types of specialty practices without an authorization from the medical group. To take advantage of Speedy Referral, simply have your primary care physician refer you to the appropriate specialist. To find out if your medical group or IPA participates in Speedy Referral, please call Customer Service at the number printed on your member ID card or contact your medical group's HMO Coordinator.

The Pharmacy Plan, ASH Chiropractic and MES Vision are the same for either Anthem Blue Cross plan that you choose. Please see pages 7-9 for more information on these plans.

Key Features of the Anthem Blue Cross PPO Plan:

- You may self-refer to see any in-network provider and are not limited to in-network providers in one medical group. However, you will pay more for these services;
- You do have out-of-network coverage. However, you will pay more for these services;
- 360°Health provides many plans and services that help you get healthy, stay healthy, and live better. Plans include personalized online access, special offers, 24/7 NurseLine and more.
- Includes MES Vision and ASH Chiropractic.

If you enroll in the Anthem Blue Cross PPO plan, you have the largest choice of health care providers because you may receive health care services from any licensed health care provider for your covered service. You do not have to select a personal physician, as you do under the HMO plan.

The PPO plan gives you the freedom to choose between an Anthem Blue Cross PPO network provider and a non-network PPO provider. The main advantage, however, is that you can receive significant cost savings when you visit Anthem Blue Cross PPO network health care providers for covered services. And, Anthem Blue Cross PPO network providers have agreed to submit any claims to Anthem Blue Cross for you.

Once you have met your annual deductible, you will pay 10% of the covered medical expenses in most cases if you visit an in-network provider. When you receive services from an out-of-network provider, the plan pays benefits based on what Anthem Blue Cross has determined is an appropriate charge for a particular service in your area. Anthem Blue Cross calls this the allowable amount. If your doctor charges more than the allowable amount covered by the plan, you will have to pay the difference in addition to your 30% of the allowable charges.

The ASH Chiropractic and MES Vision are the same for either Blue Cross Plan chosen.

Key Features of the Anthem Blue Cross Pharmacy Plan:

- *The pharmacy plan copayments differ between the plans; please see the chart on page 13.*
- Mail Order Options available through Express Scripts

The Anthem Blue Cross HMO and PPO plans provide prescription drug benefits at four different levels. Your copayment will vary depending on which category your prescription drug falls into: generic, formulary brand name, non-formulary brand name, and self-administered injectable medications.

- Generic Drugs have the same active chemical ingredients and therapeutic effect as their brand name counterparts. Although a generic drug may have a different color or shape, the Food and Drug Administration requires that it meets the same quality standards as the brand-name version. Generic drugs are your best value.
- Formulary brand-name drugs are medications included on Blue Cross's list of preferred drugs. (This list is called a formulary.) These drugs are more expensive than generic drugs.
- Non-formulary brand-name drugs are medications that are not included on Blue Cross's formulary. Many of the new drugs on the market – such as the ones you see advertised on television – would fall under this category.
- Self-administered injectable medications (except insulin) are covered at a 20% copayment up to a maximum of \$150 per prescription. Blue Cross dispenses these drugs through specialty pharmacy networks. These drugs may require authorization from Blue Cross Pharmacy Services.

Blue Cross Mail Order Drug Service is administered by Express Scripts. If you take maintenance medication (drugs you take every day like blood pressure or asthma medicine), you can save time and money by filling your prescriptions through the mail. Express Scripts generally fills a 90-day supply of medication for the cost of a 60-day supply. This means you may save an amount equal to one co-payment every three months. Our plan has additional savings for all generic prescriptions filled through mail order.

With Express Scripts, you receive accurate, quality medications – delivered right to your door. Standard shipping is free. Talk to an Express Scripts pharmacy associate and get your free, personal cost savings estimate. If you need to cancel or change an order, call 800-369-0675 or the number on the back of your member ID card. If you're having technical issues, call 877-852-4060. More information can be found on their website at <http://www.express-scripts.com/>

Key Features of the MES Vision Plan:

- Eye Exam every 12 Months
- Standard Lenses every 12 Months
- Frame Allowance every 24 Months

Medical Eye Services (MES) provides vision coverage for you if you are enrolled in one of the Blue Shield Medical Plans. This coverage includes an annual eye exam as well as hardware benefits for either glasses or contacts. Through MES, you have access to the largest vision network in California with more than 5,000 participating providers including Ophthalmologists, Optometrists, and Opticians. Participating providers include many private doctor's offices as well as retail chains such as Wal-Mart, Sears and Lens Crafters. A referral for the eye exam is not necessary. Make an appointment directly with the provider of your choice and inform them of your MES coverage.

How much you pay for vision coverage is up to you. By visiting a participating provider you maximize your dollar as these providers have accepted MES fees for covered services. If you wish, you may visit a non-participating provider but out-of-pocket expenses will be greater. The chart on page 12 provides you with a summary of MES benefits for participating and non-participating providers.

Some providers give a 20% discount for cosmetic extras, such as tints, coating and other add-on charges to standard lenses, after Covered Services are rendered. The discount may be applied to charges for the frame or contact lenses (except disposable or replacement contact lenses) over the stated allowances. The 20% discount also applies to additional pairs of glasses and/or pairs of standard contact lenses. To determine whether a provider offers the 20% discount, call MES or visit www.mesvision.com

Key Features of the ASH Chiropractic Plan:

- \$15 Copayments
- No Referral Required for Treatment

American Specialty Health (ASH) provides chiropractic coverage for you if you are enrolled in one of the Blue Cross Medical Plans. This coverage includes up to 20 visits per calendar year with a participating

provider. Each visit requires a \$15 copayment.

You can obtain services from any participating chiropractor without a referral from your Primary Care Physician. You are not required to choose a specific provider. You may choose from a list of providers who participate in the ASH network. Because the list of network providers is subject to change, you should verify whether a provider is a network provider prior to receiving services. If you are not sure about the network status of a particular provider, call AHS or visit www.ashcompanies.com. Except in case of emergencies as defined in your Certificate of Insurance, you must see a network provider in order to receive benefits. Services provided by non-network providers are not covered.

Chiropractic services are covered when a participating chiropractor finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders. Medically necessary X-rays are covered up to \$300 per calendar year when prescribed as part of your chiropractic care by a participating chiropractor and provided by an appropriately licensed participating provider who has contracted with ASH to provide those services. The chart on page 13 provides you with a summary of ASH benefits for participating and non-participating providers.

Key Features of the Kaiser California Plan:

- You must choose a PCP to coordinate your medical care needs;
- Members may self-refer to OB/GYN, nutrition, dermatology, vision, and mental health/substance abuse care providers at a Kaiser Permanente Medical Center in most cases;
- *Kaiser Permanent's Advice Line*, staffed by registered nurses, is available 24 hours a day, seven days a week, to assist a member with specific medical issues and questions;
- Includes Kaiser Vision and ASH Chiropractic Coverage;
- Kaiser LOW \$20 co-pay and Kaiser HIGH \$40 co-pay allows you to choose whether or not you want to pay higher copayments or higher monthly premium costs.

Kaiser Permanente is an HMO that provides medical care through its own hospitals and health care facilities. All Kaiser members are encouraged to select a personal physician for preventive care, treatment of illness, and referral to a specialist when needed. You may change or choose your personal physician at any time. To learn more about selecting a physician, go to www.kp.org.

You must go to a Kaiser facility and see only Kaiser doctors whenever you need medical care. Out-of-network care is not covered, except in an emergency.

As a Kaiser member, there are many programs and services available to you in addition to seeking care from your physician. By registering on Kaiser's website, you can make appointments online, email your doctor, refill prescriptions and much more.

Key Differences in the two Kaiser Plans:

- Kaiser 40 HIGH offers a lower monthly payroll deduction for a higher \$40 copayment
- Kaiser 20 LOW offers a higher monthly payroll deduction for a lower \$20 copayment
- See the chart on page 13 for a detailed comparison of the two plans

Key Features of the Kaiser Pharmacy Plans:

- *The pharmacy plan copayments differ between the Kaiser 20 LOW and the Kaiser 40 HIGH plan, please see the chart on page 13.*
- Prescriptions are available at both the Kaiser facility or via Mail Order.

Kaiser's Pharmacy Benefits:

As a Kaiser member, you will have your prescriptions filled at a Kaiser pharmacy. Kaiser's walk-in pharmacy will provide you with a 30 day supply of medication based on a two tier rate:

- Generic Drugs have the same active chemical ingredients and therapeutic effect as their brand name counterparts. Although a generic drug may have a different color or shape, the Food and Drug Administration requires that it meets the same quality standards as the brand name version. Generic drugs are your best value.
- Formulary brand name drugs are more expensive than generic drugs.

If you are registered on Kaiser's site, you can refill your prescriptions online. In most cases, Kaiser will send the refill to your home free of charge, or you can pick it up at the Kaiser pharmacy nearest you.

If you take maintenance medication (drugs you take every day like blood pressure or asthma medicine), you can save time and money by filling your prescriptions through the mail. You will receive up to a 100 day supply, for two times the price of the in person copayment. You can obtain up to a 100 day supply from the Kaiser pharmacy when you pick it up at the facility, however, you will pay more for this service. Mail order services are always your best value. For more information regarding your prescription options, go to www.kp.org.

Kaiser's Vision Benefits:

- Eye exam every 12 months
- Standard lenses and frame allowance every 24 months

As a Kaiser member, your eye care doesn't end after your eye exam. Their ophthalmologists, optometrists, and opticians work together to take care of all your eye health needs, including preventative care. If you need eyeglasses or contact lenses, you'll find a broad selection at the Optical Centers, located in the medical offices. They offer quality frames and lenses to meet every budget and lifestyle. Kaiser guarantees the frame you choose is at the lowest possible price. If you find a better price for one of their regularly stocked frames, they will match it.

The chart on page 12 provides you with a summary of Kaiser Vision benefits.

Key Features of the ASH Chiropractic Plan:

- \$15 Copayments
- No Referral Required for Treatment

American Specialty Health (ASH) provides chiropractic coverage for you if you are enrolled in one of the Kaiser Medical Plans. This coverage includes up to 20 visits per calendar year with a participating provider. Each visit requires a \$15 copayment.

You can obtain services from any participating chiropractor without a referral from your Primary Care Physician. You are not required to choose a specific provider. You may choose from a list of providers who participate in the ASH network. Because the list of network providers is subject to change, you should verify whether a provider is a network provider prior to receiving services. If you are not sure about the network status of a particular provider, call MES or visit www.ashcompanies.com. Except in case of emergencies as defined in your Certificate of Insurance, you must see a network provider in order to receive benefits. Services provided by non-network providers are not covered.

Chiropractic services are covered when a participating chiropractor finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders. Medically necessary X-rays are covered up to \$300 per calendar year when prescribed as part of your chiropractic care by a participating chiropractor and provided by an appropriately licensed participating provider who has contracted with ASH to provide those services. The chart on page 12 provides you with a summary of ASH benefits for participating and non-participating providers.

BENEFIT PLAN COMPARISON

Plan Feature or Covered Service	Anthem Blue Cross HMO 20	Anthem Blue Cross HMO 40	Anthem Blue Cross PPO		Kaiser HMO 20	Kaiser HMO 40
			Preferred Provider	Non-Preferred Provider		
Annual Year Deductible	None	None	\$250 Individual \$750 Family		None	None
Annual Maximum Out of Pocket*	\$1000 Individual \$2000 Family	\$1000 Individual \$2000 Family	\$2000 Individual \$6000 Family	\$4000 Individual \$12,000 Family	\$1500 Individual \$3000 Family	\$3000 Individual \$6000 Family
Lifetime Maximum Benefit	None	None	\$5,000,000 combined		None	None
Physician Visits	\$20 per visit	\$40 per visit	\$15 per exam	You pay 30%	\$20 per visit	\$40 per visit
Preventative Care <ul style="list-style-type: none"> • Well Baby Exams • Immunizations • Annual Adult Physical • Well Woman 	No Charge No Charge No Charge No Charge	No Charge No Charge No Charge No Charge	Deductible waived No Charge No charge No Charge No Charge	Deductible waived You pay 30% You pay 30% Not Covered You pay 30%	No Charge (0-23mo) No Charge No Charge No Charge	No Charge (0-23mo) No Charge No Charge No Charge
Specialists	\$20 per visit	\$40 per visit	\$15 per visit	You pay 30%	\$20 per visit	\$40 per visit
Allergy Visits <ul style="list-style-type: none"> • Office Visits/Testing • Allergy Serum 	\$20 per visit	\$40 per visit	You pay 10% You pay 10%	You pay 30% You pay 30%	\$20 per visit \$5 per visit	\$40 per visit \$5 per visit
Pregnancy/Maternity Care <ul style="list-style-type: none"> • Prenatal Care • Postnatal Care 	No Charge No Charge	No Charge No Charge	\$15 per visit You pay 10%	You pay 30% You pay 30%	\$5 per visit \$5 per visit	\$10 per visit \$10 per visit
Urgent Care	\$20 per visit	\$40 per visit	\$15 per visit	You pay 30%	\$20 per visit	\$40 per visit
Lab and X-ray	No Charge	No Charge	You pay 10%	You pay 30%	No Charge	\$10 per encounter
Diagnostic Scans <ul style="list-style-type: none"> • MRI, CT, PET Scan • Mammogram 	No Charge No Charge	No Charge No Charge	You pay 10% You pay 10%	You pay 30% You pay 30%	\$20 per procedure \$20 per procedure	\$50 per procedure \$50 per procedure
Outpatient Services <ul style="list-style-type: none"> • Surgery • Treatment(renal dialysis) 	No Charge No Charge	No Charge No Charge	You pay 10% You pay 10%	You pay 30% You pay 30%	\$20 per procedure \$20 per procedure	\$250 per procedure \$250 per procedure
Outpatient Rehab Therapy <ul style="list-style-type: none"> • Speech Therapy • Occupational Therapy • Physical Therapy 	\$20 per visit \$20 per visit \$20 per visit	\$40 per visit \$40 per visit \$40 per visit	You pay 10% You pay 10% You pay 10%	You pay 30% You pay 30% You pay 30%	\$20 per visit \$20 per visit \$20 per visit	\$40 per visit \$40 per visit \$40 per visit
Acupuncture	\$20 per visit	\$40 per visit	You pay 10%	You pay 30%	Not Covered	Not covered
Durable Medical Equipment	No Charge	No Charge	You pay 10%	You pay 30%	No Charge	You pay 50%
Prosthetics/Orthotics	No Charge	No Charge	You pay 10%	You pay 30%	\$20 per procedure	\$20 per procedure
Emergency Room (waived if admitted)	\$75 per visit	\$150 per visit	\$100 plus 10%	\$100 plus 10%	\$100 per visit	\$150 per visit
Ambulance	\$75 per trip	\$150 per trip	You pay 20%	You pay 20%	\$100 per trip	\$150 per trip

Inpatient Hospitalization • Admission Fee • Inpatient Services	No Charge No Charge	No Charge No Charge	Not applicable You pay 10%	\$500 per event You pay 30%	No Charge No Charge	\$500 per event No charge
Skilled Nursing Facility	No Charge	No Charge	You pay 10%	You pay 30%	No Charge	No Charge
Home Health Care	No Charge	No Charge	You pay 10%	You pay 30%	No Charge	No Charge
Hospice	No Charge	No Charge	You pay 20%	You pay 20%	No Charge	No Charge
Mental Health – Inpatient	No Charge	No Charge	You pay 10%	\$500 plus 30%	No Charge	\$500 per admission
Mental Health – Outpatient • Facility based care • Outpatient physician visit	No Charge \$20 per visit	No Charge \$40 per visit	You pay 10% \$15 per visit	You pay 30% You pay 30%	\$10 group \$20 individual	\$20 group \$40 individual
Prescription Drugs	Retail – 30 Day \$10 Tier 1 \$20 Tier 2 \$30 Tier 3 20% Tier 4 Mail – 90 Day \$10 Tier 1 \$40 Tier 2 \$60 Tier 3 20% Tier 4	Retail – 30 Day \$15 Tier 1 \$30 Tier 2 \$45 Tier 3 20% Tier 4 Mail – 90 Day \$15 Tier 1 \$60 Tier 2 \$90 Tier 3 20% Tier 4	Retail – 30 Day \$5 Tier 1 \$15 Tier 2 \$30 Tier 3 20% Tier 4 Mail – 90 Day \$5 Tier 1 \$30 Tier 2 \$60 Tier 3 20% Tier 4	Retail – 30 Day \$5 Tier 1 \$15 Tier 2 \$30 Tier 3 20% Tier 4 Mail – 90 Day \$5 Tier 1 \$30 Tier 2 \$60 Tier 3 20% Tier 4	Retail: Generic Brand 30 day \$10 \$20 60 day \$20 \$40 90 day \$30 \$60 Mail: Generic Brand 30 day \$10 \$20 100 day \$20 \$40	Retail: Generic Brand 30 day \$15 \$35 60 day \$30 \$70 90 day \$45 \$105 Mail: Generic Brand 30 day \$15 \$35 100 day \$30 \$70

*Does not include Copays, Penalties, Deductible, or charges over the reasonable and customary limits

All medical plan options are bundled with the following Chiropractic and Vision Hardware Benefits.

Vision Hardware	Anthem Blue Cross HMO or PPO		Kaiser
	MES In-Network	MES Out-of-Network	Kaiser Network Only
Eye Exam	\$10 per visit	Plan will reimburse you \$60 Ophthalmologic \$50 Optometric	\$20 per exam (Kaiser 20 LOW) \$40 per exam (Kaiser 40 HIGH)
Standard Lenses	No Charge every 12 mo.	Plan will reimburse you \$30 Single \$50 Bifocal \$65 Trifocal \$125 Lenticular	No Charge every 24 mo.
Frame Allowance	No charge up to \$300 every 24 mo.	Plan will reimburse you \$40	No Charge up to \$300 every 24 mo.
Contact Lenses • Cosmetic • Medically necessary	No charge up to \$100 every 12 mo. No Charge with authorization	Plan will reimburse you \$100 Plan will reimburse you \$250	No charge up to \$300 every 24 mo. No charge with authorization

Chiropractic	Benefits are the same regardless of Medical Plan Chose		
	ASH In-Network	ASH Out-of-Network	Plan Maximum Benefits
Office Visits	\$15 per visit	Only covered for emergency services	20 visits per insured, per calendar year
X-ray, Radiological consultations	No Charge up to \$300	Only covered for emergency services	\$300 per insured, per calendar year
Supports and Appliances	No Charge up to \$50	Only covered for emergency services	\$50 per insured, per calendar year

Your Dental Plan Choices

This section gives you a broad overview of your dental coverage options for 2011-2012.

For the 2011-2012 fiscal year, you may choose one of the following dental plan options:

- Delta Dental DeltaCare; or
- Delta Dental PPO

Each plan provides coverage for a variety of dental services. The difference is how the plans pay benefits for this care. The chart below compares the coverage under each plan for the different types of services. The election form shows the cost of coverage for 2011-2012.

Key Features of the DeltaCare Plan:

- You must choose a participating dentist office;
- You do not have a benefit maximum. This means that Delta Dental will continue to pay for any necessary and covered services throughout the plan year regardless of costs incurred by Delta Dental.

Key Features of the Delta Dental PPO Plan:

- You may receive services from any dentist office, however you will pay more for services received by an out-of-network dentist;
- You do have a benefit maximum. This means that Delta Dental will not pay out more than \$1250 per person per *calendar* year. Once this maximum is reached, you are responsible for 100% of your dental costs until the next *calendar* year.

Plan Feature or Covered Service	DeltaCare	Delta Dental PPO	
	In-Network Only	In-Network	Out-of-Network
	Delta Preferred	Delta Preferred	Delta Premier or Non-Delta
Annual Benefits Maximum	Not Applicable	\$1250 per person not including Orthodontia Benefits	
Annual Year Deductible	Not Applicable	None	\$50 Individual \$150 Family
Preventive Services	No Charge	100% of Delta Approved Fee	80% of Delta Approved Fee
Basic Services Fillings/Root Canals	See co-pay schedule*	90% of Delta Approved Fee	80% of Delta Approved Fee
Major Services Crowns, Bridges, Dentures	See co-pay schedule*	80% of Delta Approved Fee	50% of Delta Approved Fee
Orthodontic Benefits	Plan pays up to the following: \$950 child/\$1150 adult	50% of Delta Approved Fee	
		\$1250 Orthodontia Lifetime Maximum per person	

*The full co-payment schedule is available on SBCCD's website, as well as in your plan description.

About your Employee Assistance Program (EAP)

For all Benefit Eligible employees, the District also pays for an Employee Assistance Program (EAP). The EAP is provided to you by ACI Specialty Benefits. The EAP is designed to help you and your family members better manage whatever issues come your way and ultimately improve the quality of life at home and at work.

What kinds of concerns are covered?

The EAP is designed to help with any concern or problem affecting your behavioral health, well-being, or even job performance. Typical concerns may include, but are not limited to:

Relationship Issues

- Marital stress
- Family issues
- Parenting issues
- Blended families
- Conflict Resolution

Emotional Well-being

- Depression
- Managing stress
- Coping with grief
- Addictive disorders
- Healthy attitudes

Legal/Finance

- Legal resources
- Financial planning
- Legal referrals
- Bankruptcy & Foreclosure
- Credit problems

Workplace Challenges

- Managing change
- Dealing with conflict
- Supervisory concerns
- Balancing work/life
- Time management

Concierge

- Event Planning
- Errand Runners
- Reservations & Tickets
- Cleaning Services
- Entertainment
- Consumer Information
- Personal Safety
- Transportation & Travel
- Maintenance Service
- Car Repairs & Rentals
- Moving & Relocation
- Home Repairs

How will the EAP help me?

Simply call ACI EAP at (800) 932-0034 to speak with a professional service provider face-to-face, by phone, email or event text! You will be asked to briefly describe your concerns so that you and the provider can develop a plan that works best for you. This plan may include assessment, brief sessions, and/or referral to other helpful resources. All contact with the EAP is strictly confidential.

Who pays for these services?

The EAP services have been prepaid by your employer and are **free** to you. Should you need help beyond the EAP, you may be referred to community and other resources. Health insurance may cover some of these costs. The EAP provider will work with you to make the referral is affordable and meets your need.

Who can use these services?

The EAP services are not limited to the family members on your health plan. Any family members, in any state, can call and use the services. They must only identify that their family member works at San Bernardino Community College District.

What services are unlimited?

- Legal Consultation: Attorneys are available by phone to provide unlimited consultation
- Financial Consultation: Financial planners and debt consolidation specialist are available by phone to assist with all type of credit and money issues.
- Childcare Referrals: You have access to a national network of resources to address a wide range of childcare concerns.
- Eldercare Referrals: Whether the elder loved one requires financial, legal, housing or any other assistance, let the EAP help with any dependent care needs.
- Concierge Services: You have access to a “personal assistant” to help with everyday consumer issues.

About Flexible Spending Accounts (FSAs)

You can set aside pre-tax money in two types of accounts that reimburse you for eligible health care and dependent day care expenses. These accounts are:

- Medical Expenses FSA; and
- Dependent Day Care FSA

The two accounts are separate – you may not use the Health Care FSA for dependent day care expenses or vice versa. Both accounts are administered by American Fidelity.

Medical Expenses FSA

The maximum amount you can contribute for 2011 is \$2,400. You may elect to contribute to a Medical Expenses FSA and use the money in your account to pay for eligible health care expenses that are deductible on your federal income tax return. You cannot be reimbursed for health care premiums or any expenses which are or will be reimbursed by a health, dental, or vision plan.

In order to participate in the plan for 2011-2012, you must enroll with an American Fidelity Representative during Open Enrollment. Your current 2010-2011 election does not carry over for 2011-2012. For a complete list of what the IRS considers eligible health care expenses, go to ww.afadvantage.com.

For 2011-2012, you now have the convenience of using the ***SmartFlex Debit Card***. It looks and works like a regular credit card, but the *SmartFlex* Debit Card directly withdraws available funds from your Medical Reimbursement Account. It provides instant medical reimbursement, without you having to pay for your qualified expense upfront and waiting to be reimbursed for your payment. For more information, speak with an American Fidelity representative. There is a small fee associated with the *SmartFlex* Debit Card. If you choose to receive one, there is a **\$2.92 monthly participation fee** for employees receiving 12 paychecks per year. This rate is prorated for any employee receiving less than 12 paychecks.

Dependent Day Care FSA

You may elect to participate in a Dependent Day Care FSA and use the money in your account to pay for eligible day care expenses for a child or dependent adult, including expenses for day care provided in your home, someone else's home, or a day care center. Eligible expenses generally are those that allow you (or you and your spouse if you are married) to work. Eligible dependents include your children under age 13 whom you claim on your federal income tax return, or a dependent adult who is incapable of self-care and who spends at least eight hours a day in your home.

In order to participate in the plan for 2011-2012, you must enroll with an American Fidelity Representative during Open Enrollment. Under present tax laws, the maximum amount you may set aside in a Dependent Day Care FSA is:

- \$5,000 if you are single, or if you are married filing a joint income tax return. If your spouse is contributing to an FSA, together you and your spouse can contribute no more than \$5,000; or
- \$2,500 if you are married and file a separate return

In addition, the amount you may set aside cannot be more than your spouse's earned income. However, there are special rules that apply to spouses who are full-time students, looking for work, or disabled. If your spouse falls into that category, please call your tax advisor for assistance. For a complete list of what the IRS considers eligible day care expenses, go to www.afadvantage.com.

About Voluntary Life Insurance

The addition to the \$30,000 Basic Life Insurance benefits provided by the District at no cost to you, the District offers you the opportunity to elect additional protection for yourself and your family.

Employee Voluntary Life Insurance

You may elect additional life insurance or increase your existing coverage. Coverage is available from \$10,000 to a maximum of \$300,000 in increments of \$10,000 not to exceed 5 times your annual earnings (rounded to the next highest \$10,000.) Coverage may not exceed five times your basic annual salary.

- You are guaranteed (GI Limit) two times your basic annual earnings up to \$100,000, whichever is less, without proof of good health **upon hire**. If you apply for amounts in excess of the GI Limit or apply for coverage after your initial enrollment period, proof of good health satisfactory to Prudential must be provided by completing an Evidence of Insurability (EOI). Once your EOI is reviewed and your request is approved, your additional coverage will become effective.
- For employees who are actively at work, benefit amounts reduce to 65% of original coverage at age 70, 50% of original coverage at age 75 or more.
- Accidental Death and Dismemberment (AD&D) coverage is automatically equal to your supplemental life insurance.
- For employees who are actively at work, benefit amounts reduce to 65% of original coverage at age 65, 50% of original coverage at age 70 and 30% at age 75.

Employee Rate Information

- The rate is based on your age on July 1 of every year, and will automatically increase when you advance into the next higher age bracket.
- Rates do not include Accidental Death and Dismemberment, which is available as separate coverage.
- Rates are calculated assuming you receive 10 or 12 paychecks per year.

Employee's Age	Monthly Rate per \$1,000	Tenthly Rate per \$1,000
Less than 30	.04	.05
30-34	.04	.05
35-39	.06	.07
40-44	.09	.11
45-49	.16	.19
50-54	.24	.29
55-59	.39	.47
60-64	.65	.78
65-69	1.09	1.31
70-over	1.85	2.22

Sample Employee Voluntary Coverage Calculation

Ann Smith is a 35 year old who applies for \$100,000 of Voluntary Life Coverage. She is a 12 month employee.

She follows these steps to calculate her voluntary coverage:

\$100,000 divided by 1,000 = 100

100 times \$.07 = \$7.00

Her monthly premium for \$100,000 of voluntary life is \$7.00 per month

Voluntary Life Insurance for your Spouse

If you are covered for Supplemental Life, you may apply for spouse Supplemental Life coverage in increments of \$5,000, not to exceed \$300,000. Your spouse can only participate if you have NOT been denied coverage.

- The **guaranteed issue (GI)** for your spouse coverage is up to \$20,000 without providing proof of good health upon hire. However if you apply for amounts in excess of the GI Limit; or if you apply for coverage outside of your initial enrollment period, proof of good health satisfactory to Prudential must be provided by completing an Evidence of Insurability (EOI).
- For employees who are actively at work, benefit amounts reduce to 65% of original coverage at age 70, 50% of original coverage at age 75 or more.
- Spouse coverage may not exceed 100% of your approved coverage. If your spouse is also a benefit eligible employee of the district, they are not eligible to be covered under your policy.
- Rates for spouse coverage are the same as employee coverage.

Voluntary Life Insurance for your Dependent Child(ren)

If you are covered for voluntary life insurance, you may apply for voluntary life coverage for your children in the amount of \$2,500, \$5,000, or \$10,000.

- If you and your spouse are both eligible as an employee, your children may be insured as dependent children of either you or your spouse, but not both of you.

Rate Information

- Rates do not include Accidental Death and Dismemberment, which is available as separate coverage.
- Child benefit under age 6 months is \$100
- Rate is the same whether for one child, or two or more children.

Child Coverage	Monthly Rate	Tenthly Rate
\$2,500	.60	.72
\$5,000	1.00	1.20
\$10,000	2.00	2.40

Eligibility Details for Voluntary Life Insurance

Employee: (1) if your employer requires that you must be continuously employed by them for a minimum number of days, you must be continuously employed for at least that number of days; and (2) you must be actively performing the regular duties of your job for at least the required number of hours as defined in the group contract and work in the usual manner and at the usual place of employment or business (if you are not working due to illness or injury, you will not be eligible until you return to work); and (3) you must give us evidence of insurability satisfactory to us, if we ask for it. If you are not working due to illness or injury, you will not be eligible until you return to work.

Spouse: Your spouse who is legally married (as determined by the laws of the state in which you live) to you is eligible to participate in this program. Spouse also means your Registered Domestic Partner* as defined in the group contract. A spouse does not include anyone who is personally eligible as an employee. You must be covered in order for your spouse to be eligible for coverage.

*Your registered domestic partner means a person whose domestic partnership with you has been validly registered by the California Secretary of State; or a person with whom you have established a union other than marriage, recognized under California law as the equivalent of a registered domestic partner.

Dependent Children: Dependent children are your children from live birth to 26 years old. Your children include your legally adopted children, children placed with you for adoption prior to legal adoption, and each of your stepchildren, domestic partner's children, children for whom you are the legal guardian and foster children who depend on you for support and maintenance. A child placed with you for adoption prior to legal adoption is considered your qualified dependent from the date of placement for adoption and is treated as though the child were a newborn child born to you. A dependent child does not include anyone who is personally eligible as an employee. If you and your spouse are both eligible as an employee, your children may be insured as dependent children of either you or your spouse, but not both of you. You must be covered in order for your dependent children to be eligible for coverage. A qualified dependent may be confined for medical care or treatment at home or elsewhere. If a qualified dependent is so confined on the day that your

dependents insurance, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the qualified dependent's final medical release from all such confinement. The other requirements for the insurance or change must also be met.

Highlights of Voluntary Life Insurance

Waiver of Premium

The premium will be waived for you, your spouse, and your children if you, the employee, are insured and become totally disabled for at least six consecutive months. Your total disability must occur while coverage is in force and prior to your attaining age 70. During the six month waiting period, premiums for all coverage must be paid. Limitations and exclusions apply. Refer to the group contract for details.

Accelerated Death Benefit

The Accelerated Death Benefit for terminal illness allows individuals to "tap into" life insurance proceeds early. You can receive up to 75% of the applicable voluntary group term life insurance amount in the event of an insured's terminal illness. The maximum benefit payable under this option is \$250,000. The balance of the coverage will be paid to the beneficiary at the death of the insured. Limitations and exclusions apply. Refer to the group contract for details.

Conversion to Permanent Coverage

If your employment terminates for any reason or an insured becomes ineligible, you and your family may convert your voluntary coverage to permanent whole life insurance. In addition, if your insured dependents are no longer eligible for group insurance under your certificate, they may convert their insurance coverage to permanent whole life insurance. Additional requirements and limitations will apply if your coverage terminated because the group contract terminates. You (or your insured dependent) must sign an application for conversion within 31 days following the termination of your employment or eligibility (or dependent insurance ends) in order to convert your coverage without being required to submit additional health evidence. Coverage will be billed monthly. No additional fees for direct payment will apply under this option.

Continuation of Coverage

If your employment terminates for any reason or you become ineligible, you and your covered family may continue your voluntary group term life insurance coverage on a direct payment basis at the same rate as long as the group contract remains in effect. YOU MUST CONTINUE your coverage in order to continue dependent coverage. If you elect this option, you will be billed on a semi-annual or annual basis. A fee per billing will apply and your premium cost is subject to change. You must sign an application for continuation within 31 days following the termination of your employment or eligibility. An insured on continued coverage may apply for conversion to permanent coverage at any time, but in no event more than 31 days after the termination of the group contract.

Exclusions for Voluntary Life Insurance

Suicide Exclusion

If you or your covered dependent's death results from or is caused by suicide, while sane or insane: (1) A death benefit is not payable if you or your covered dependent dies within two years of the date you or your covered dependent became a covered person. But, Prudential will refund any premiums paid for your employee term life insurance or dependent term life insurance under this coverage. (2) The amount of any increase in you or your dependent's death benefit is not payable if you or your covered dependent dies within two years of the date of the increase. But, Prudential will refund any premiums paid for that increase.

Beneficiary

You designate your own beneficiary. You, as the employee, will be the beneficiary of your spouse and/or children's insurance.

About Voluntary AD&D Insurance

As an employee of San Bernardino Community College District, you are eligible to receive \$2,000 of AD&D coverage. You are also eligible to enroll for additional amounts of Voluntary AD&D coverage at competitive rates for you and qualified family members.

Key Features of Voluntary AD&D Insurance:

- Eligible for AD&D coverage independent of voluntary life coverage
- FREE \$2,000 policy offered to ALL benefit eligible employees during Open Enrollment

Coverage and Eligibility

AD&D Coverage provides 24-hour All Risk Accidental Death and Dismemberment, including paralysis and coma benefits. All benefit eligible employees are eligible for \$2,000 of Accidental Death and Dismemberment coverage. Each employee may purchase additional amounts of coverage on a voluntary basis. Plans that extend coverage to the employee's spouse and dependent children are also available. Qualified dependents include the employee's legal spouse, domestic partner, and dependent children under age 26. If both parents are eligible, the children may be covered as dependents of only one parent. A person insured as an employee may not be covered as a spouse or dependent of another employee.

Employee Benefit Amount Options

Employee may elect a benefit in the amount of \$10,000, \$25,000, \$50,000, \$100,000, \$250,000, and \$500,000. Amounts exceeding \$100,000 may not exceed 10 times annual base earnings.

Qualified Dependents (Spouse and Dependent Children)

If employee elects to cover their spouse and dependent children, benefit amounts will be as follows:

- Spouse – 60% of employee's principal amount (less \$2000)
- Child(ren) – 25% of employee's principal amount (less \$2000 and not to exceed \$50,000)

At age 70, the employee's benefit amount will reduce to 50%. Qualified dependent benefits will reduce proportionately, independent of age when the employee reaches age 70.

100% of the Full Amount Insurance +\$2,000	75% of the Full Amount of Insurance +\$1,500	50% of the Full Amount of Insurance + \$1,000	25% of the Full Amount of Insurance +\$500
Loss of life or loss of two or more members* or loss of speech and hearing of both ears Quadriplegia (total paralysis of both upper and lower limbs).	Paraplegia (total paralysis of both lower limbs)	Loss of one member* or Loss of speech or hearing of both ears Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	Loss of hearing of one ear or loss of thumb and index finger of the same hand

*Member means hand, foot, or eye. Loss must occur within 365 days of the date of the covered accident.

Loss Due to Exposure and Disappearance

Loss resulting from exposure to the elements shall be covered to the extent of the benefits afforded an insured. If the body of an insured has not been found within one year of the disappearance, stranding, sinking, or wrecking of any vehicle in which an insured was an occupant, it shall be presumed subject to all other provisions and conditions of the policy, than an insured has suffered loss of life covered under this policy.

Additional Benefits

MONTHLY COMA BENEFIT

If a covered insured is injured in a covered accident that results in a coma for at least 31 consecutive days, the plan will begin payment of a monthly coma benefit. Payment of this benefit will continue each month as long as the covered person remains in a coma, up to a maximum of 100 months. This benefit will be paid at a rate of 1% of the amount of insurance less any benefits paid as a result of the same covered accident. "Coma" means being in a profound state of unconsciousness from which the person cannot be aroused, even by powerful stimulation, as determined by the person's doctor.

DEPENDENT CHILD LOSS BENEFIT

If a child suffers paralysis or dismemberment, the plan provides an additional amount of insurance equal to 100% of the amount payable for the one largest amount to which the child is entitled.

CONTINUED ACCIDENT INSURANCE AFTER YOUR DEATH

If you elect the spouse and/or dependent coverage and die in a covered accident, your family's coverage will be continued, at no cost to your family, for a period up to 12 months from the date of your death, provided your spouse and/or dependent children remain eligible under the plan. At the end of the 12-month period, coverage ends.

CHILD CARE EXPENSE BENEFIT

If you elect the spouse and/or dependent children coverage and you or your insured spouse die in a covered accident, the plan will provide child care assistance to each eligible dependent child under the age of 13 who is enrolled in a licensed child care center, or who enrolls in a licensed child care center within 90 days from the date of the covered accident. This important benefit pays 5% of the applicable amount of insurance up to \$5000 yearly for up to four consecutive years, but not beyond the date the child reaches age 13. If you have no eligible children who qualify, the plan will pay \$1,000 to your beneficiary.

TUITION REIMBURSEMENT BENEFIT FOR SPOUSE

If you elect to cover your spouse and you die in a covered accident, the plan will provide a tuition reimbursement benefit to your eligible spouse. A spouse must enroll within 365 days of your death in a training program for the purpose of obtaining an independent source of income. This tuition reimbursement benefit is a lump sum payment of 5% of your amount of insurance or \$5,000, whichever is less.

TUITION REIMBURSEMENT BENEFIT FOR CHILDREN

If you elect to cover your spouse and children and you or your insured spouse die in a covered accident, the plan will provide a tuition reimbursement benefit to each eligible dependent child who is a full-time student at a college, university, vocational school, or trade school over the 12th grade level at the time of (or enrolls within 365 days of) your death. This tuition reimbursement benefit is an annual payment of 5% of the applicable amount of insurance or \$5,000, whichever is less. Payments will be made each year for up to four consecutive years for each child who qualifies, but not beyond the date the child reaches age 25. Benefit payments will cease when the child ceases to be a full-time student. If there are no dependent children who qualify for this benefit, a single lump-sum of \$1,000 will be paid to your beneficiary.

SEAT BELT BENEFIT

Because of the added protection seat belts bring to drivers and passengers every day, this special benefit is provided for you and your family members. If, while insured for this benefit, you or your covered dependent suffer accidental death due to a covered accident in which you or your covered dependent were seated in a n automobile with a seat belt properly fastened, the plan will pay an additional 10% of the entitled amount of insurance, to a maximum of \$25,000.

CRITICALLY BURNED BENEFIT

If you are accidentally critically burned over 25% of your body (above second degree burns) and/or permanently disfigured to the point of requiring reconstructive or cosmetic surgery, a critically burned benefit shall be payable. This benefit will be 25% of your principal sum or \$25,000, whichever is less.

PORTABILITY BENEFIT

Coverage will end on termination of employment as specified in the contract. You may continue your group insurance through a portability provision if you meet all of the following criteria. Your voluntary AD&D coverage ends for any reason other than your failure to pay, when, due, any contribution required for it; or the end of your employment on account of your retirement; or the end of the coverage for all employees when such coverage is replaced by Group AD&D insurance from any carrier for which you are or become eligible within 31 days. You must also meet the active work requirement on the day your insurance ends, you are less

than age 80 and your amount of insurance is at least \$20,000 under the Voluntary AD&D coverage on the day your insurance ends.

Additional Information

BENEFICIARY

You may name any beneficiary or beneficiaries you wish. If you purchase coverage for your family under the family plan, you are automatically your dependent's beneficiary for loss of life.

EFFECTIVE DATE OF COVERAGE

Your coverage will be effective on the first day of the month following the date your completed enrollment form is received by the contract holder.

TERMINATION OF COVERAGE

Insurance will continue as long as the insured remains eligible through the contract holder, continue to pay the premiums, and the master contract is not terminated. Coverage for your dependents will terminate when your coverage terminates, or when they no longer qualify under the plan.

EXCLUSIONS AND LIMITATIONS

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department. A loss is not covered if it results from suicide or attempted suicide, while sane or insane; intentional self-inflicted injuries, or any attempt to inflict such injuries; sickness, whether the loss results directly or indirectly from sickness; medical or surgical treatment of sickness; whether the loss results directly or indirectly from the treatment; any bacterial or viral infection. But, this does not include: a pyogenic infection resulting from an accidental wound or cut; or a bacterial infection resulting from accidental ingestion of a contaminated substance; taking part in any insurrection; war, or any act of war. War means declared or undeclared war, and includes resistance to armed aggression; an accident that occurs while the person is serving on full time active duty for more than 30 days in any armed forces. But this does not include Reserve or National Guard active duty for training; commission of or attempt to commit an assault or a felony; travel or flight in any vehicle used for aerial navigation, if the person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; the person is performing as a pilot or a crew member of any aircraft; or the person is riding as a passenger in an aircraft owned, operated, controlled or leased by or on behalf of the contract holder or any of its subsidiaries or affiliates; except as prescribed by a Doctor, use of: (1) PCP (also known as "Angel Dust"); (2) LSD or other hallucinogens; (3) cocaine, heroin, or other narcotics; (4) amphetamines or other stimulants; (5) barbiturates or other sedatives or tranquilizers; or (6) any combination of two or more of these substances; any poison or gas voluntarily taken, administered, absorbed, or inhaled (except in the course of employment). This provision may vary by state. Refer to the plan booklet for details.

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under the law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

This plan is issued by the Prudential Insurance Company of America, Newark, New Jersey. Life Claims: 1-800-524-0542. Please refer to the Booklet-Certificate, which is made a part of the group contract for all plan details, including any exclusions, limitations, and restrictions which may apply. If there is a discrepancy between this document and the booklet-certificate/group contract issued by the Prudential Insurance Company of America, the terms of the Group contract will govern. Contract provisions may vary by state. Contract Series: 83500. Correspondence may be directed to the Program Administrator: The Prudential Insurance Company of America c/o Johnson Rooney Welch, Inc. 2250 Douglas Blvd., Suite 210, Roseville, CA 95661.

General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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 the Office of Human Resources.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Plan Contact Information

San Bernardino Community College District
Human Resources
114 S. Del Rosa Drive
San Bernardino, CA 92408

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

Important Notice from San Bernardino Community College District About Your Prescription Drug Coverage and Medicare

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current San Bernardino Community College District coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current San Bernardino Community College District coverage, be aware that you and your dependents will not be able to get this coverage back.

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 [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every

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month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

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

Contact the person listed below for further information or call Keenan & Associates at (800) 654-8347. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through San Bernardino Community College District changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	April 2011
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