

The LACCD Joint Labor/Management
Benefits Committee presents

Health Benefits

Highlights Booklet



ACTIVE EMPLOYEES

Annual Enrollment 2009

November 3 – November 26, 2008

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JOINT LABOR-MANAGEMENT
BENEFITS COMMITTEE

IMPORTANT CONTACT INFORMATION

Medical Plans

Blue Shield

P.O. Box 272540
Chico, CA 95927-2540
(800) 443-5005
www.blueshieldca.com

U.S. Behavioral Health Plan

(mental health services administrator
for the Blue Shield medical plans)
(877) 263-8827
www.unitedbehavioralhealth.com

Kaiser Permanente

(800) 464-4000
www.kp.org

Dental Plans

Delta Dental

P.O. Box 997330
Sacramento, CA 95899-7330
(800) 765-6003
www.deltadentalins.com

SafeGuard

P.O. Box 3594
Laguna Hills, CA 92654
(800) 880-1800
www.safeguard.net
(plan code SGC1028)

Vision Plan

VSP

P.O. Box 997100
Sacramento, CA 95899-7105
(800) 877-7195
www.vsp.com

Flexible Spending Accounts (FSAs)

SHPS, Inc.

11405 Bluegrass Pkwy.
Louisville, KY 40299
(800) 678-6684
www.myshps.com

Employee Assistance Program (EAP)

Horizon Health

(800) 342-8111
www.horizoncarelink.com
login code: laccd
password: eap

Term Life and AD&D Insurance

LACCD

770 Wilshire Blvd.
Los Angeles, CA 90017
(213) 891-2200
www.laccd.edu/health

MetLife

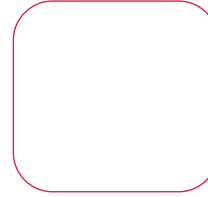
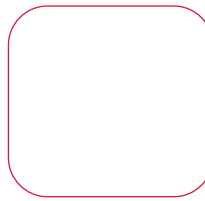
National Service Center
P.O. Box 2517
Aurora, IL 60507-2517
(877) ASK-MET7
www.metlife.com

Other Benefits & COBRA Information

LACCD Health Benefits Call Center

770 Wilshire Blvd., 6th Floor
Los Angeles, CA 90017
(888) 428-2980
www.laccd.edu/health





Your LACCD Health Benefits Program

The Los Angeles Community College District is proud to provide a generous and comprehensive package of benefits to help you take care of yourself and your family.

LACCD pays the full cost of medical, dental, vision, and EAP coverage for you and your eligible dependents. You also receive District-paid life and accidental death and dismemberment insurance. As a value-added benefit, you may buy additional life insurance coverage and/or enroll in a flexible spending account (FSA).

For more information about your benefits—including eligibility information and a summary of your legal rights under the plans—please visit www.laccd.edu/health.

This summary describes the key features of the benefits available to active full-time employees and their eligible dependents. It is only intended to provide the highlights of your benefits; see your Evidence of Coverage or plan document for full details. If any conflict ever arises between this summary and the actual Evidence of Coverage or other plan document, the terms of the plan document will govern in all cases. LACCD reserves the right to change, modify, or terminate the benefit plans at any time. This summary is not a contract for purposes of employment or payment of benefits.

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MEDICAL PLANS

LACCD offers you three medical plan options:

- Blue Shield Spectrum PPO
- Blue Shield Access+ HMO
- Kaiser Permanente HMO

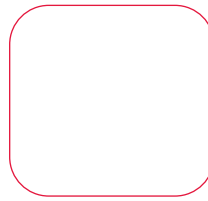
How a PPO works. A preferred provider organization (PPO) is a network of doctors and health care facilities that provide services to plan members at special discounted rates. You can go directly to any doctor you like within the PPO network. You also have the option of going to a doctor or health care facility that does not belong to the PPO network, but you will pay more for your care if you do.

How an HMO works. A health maintenance organization (HMO) is a network of doctors and health care facilities that closely manage your medical care to control your out-of-pocket costs. There are no deductibles to pay and no claim forms to fill out. You'll make a small copayment for certain services, like routine visits to your doctor; other services, such as hospitalization, are covered at no charge to you. If you enroll in an HMO, you must receive all of your non-emergency care within the HMO network, or the plan will not pay benefits.

Blue Shield Spectrum PPO

You can go to any doctor you like within the Blue Shield PPO network, including specialists. You do not have to select a personal physician, as you do with an HMO. You also have the option of going to a doctor or health care facility that does not belong to the PPO network, although your out-of-pocket expenses will be higher.

The main differences between these medical plan options are how much flexibility you have in choosing a provider and how much you spend on out-of-pocket health care expenses.



In the PPO network. When you go to a provider within the PPO network, most services are provided at no cost to you after you pay an annual deductible of \$200 per person (to a maximum benefit of \$600 per family). You will pay only a copayment for physician office visits and prescription drugs. There are no claim forms to fill out when you go to a network provider.

Outside the PPO network. If you go to a doctor or health care facility that does not belong to the PPO network, you will pay 20% of your covered medical expenses after meeting the deductible. If your share of the medical expenses reaches an amount called the **copayment maximum**, you will not have to make any more copayments for the rest of the calendar year. Your copayment maximum for out-of-network care is \$1,000 per person (or \$3,000 per family).

When you receive services from an out-of-network provider, the plan pays benefits based on what Blue Shield has determined is an appropriate charge for a particular service in your area. Blue Shield 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.

If you go to an out-of-network provider, you will pay the provider directly for the full cost of your care. You will then submit a claim to Blue Shield to be reimbursed for the covered portion of your bill. Claim forms are available at www.laccd.edu/health.

The chart on page 5 shows the highlights of the PPO plan. Please see your Evidence of Coverage (available at www.laccd.edu/health) for complete information on the plan's benefits, limitations, and exclusions.

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

Blue Shield Access+ HMO

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

Your personal physician 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 Shield.

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

- Women may go directly to a gynecologist or family practice physician in their personal physician's medical group or practice association without a referral.
- You have the option of selecting your own specialist, as long as your personal physician is part of a provider group that offers the *Access+Specialist* feature. You must choose a specialist in the same medical group or practice association as your personal physician. If you choose to go to a specialist without a referral from your personal physician, you will pay a \$30 copayment for each office visit. If you have a referral from your personal physician, visits to that specialist will only cost you a \$5 copayment.
- Non-emergency mental health or substance abuse services must be arranged directly through U.S. Behavioral Health, which administers Blue Shield's mental health/substance abuse benefits.



Kaiser Permanente HMO

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.

The chart on page 4 compares the key benefits under both HMO plans. Please see your Evidence of Coverage (available at www.laccd.edu/health) for complete information on each plan's benefits, limitations, and exclusions.

Health & Wellness Programs

Blue Shield offers a number of resources to help you manage your health.

- **Health education programs** teach you how to maintain a healthy lifestyle.
- **Health management programs** help you live with chronic conditions like diabetes or asthma.
- **Healthy Lifestyle Rewards** is an interactive, online program that helps you adopt and maintain healthy lifestyle habits.
- **Lifepath Advisers** gives you a confidential 24-hour resource for personal issues and nurse line services.
- **Lifepath Decision Guide** is a collection of tools to help you compare hospitals, evaluate treatment options, and research drugs on the Blue Shield formulary.
- **The health library** contains a wealth of information on health care topics.

These resources are available to Blue Shield members at no cost. To find out more, go to www.blueshieldca.com and click on the *Health & Wellness* tab.

	Kaiser Permanente HMO	Blue Shield Access+ HMO
	Kaiser Network Only	Blue Shield Network Only
Where You Go for Care	All care must be received at a Kaiser health care facility	All care must be coordinated by your primary care physician
Calendar Year Deductible	None	None
Calendar Copayment Maximum	\$1,500/person; \$3,000/family	\$500/person; \$1,500/family
Lifetime Maximum Benefit	Unlimited	Unlimited
Covered Services	What You Pay	
Physician Office Visits	\$10 per visit	\$5 per visit
Preventive Care (includes routine physicals and well-woman exams)	\$10 per visit	No copayment
Well-Child Care (includes routine exams and immunizations)	No copayment	No copayment
Maternity (pre- and post-natal office visits)	No charge for pre-natal visits and first post-natal visit; \$10 copayment for subsequent post-natal visits	No copayment
Inpatient Hospital Services	No copayment	No copayment
Outpatient Surgery	\$10 per procedure	No copayment
Emergency Room Services	\$50 per visit (waived if admitted directly to the hospital)	No copayment
Physical, Occupational, or Speech Therapy	\$10 per visit	\$5 per visit
Chiropractic Care	Not covered	\$10 per visit; limited to 30 visits per calendar year (combined with acupuncture)
Acupuncture	Not covered	\$10 per visit; limited to 30 visits per calendar year (combined with chiropractic care)
Durable Medical Equipment	No copayment	No copayment; benefit limited to \$2,000 per calendar year
Hearing Aids	No copayment; limited to \$500 allowance every 36 months	20%; benefit limited to \$2,000 every 24 months
Home Health Care	No copayment; limited to 100 2-hour visits per calendar year	\$5 per visit; limited to 100 visits per calendar year
Skilled Nursing Facility	No copayment; limited to 100 days per calendar year	No copayment; limited to 100 days per calendar year
Mental Health Services*		
▪ Inpatient Care	No copayment; limited to 45 days per calendar year	No copayment
▪ Outpatient Care	\$10 copayment/private visit; \$5 copayment/group visit No limit on visits	\$25 per visit for non-severe conditions; limited to 20 visits per calendar year (combined with outpatient substance abuse care) \$5 per visit for severe conditions; no limit on visits
Substance Abuse Services		
▪ Inpatient Care	No copayment for detoxification only; \$100 copayment per admission for transitional residential recovery services (up to 60 days per calendar year)	No copayment for detoxification only; \$50 per day for additional inpatient care and \$25 per day for partial hospitalization/day treatment (at a U.S. Behavioral Health network facility)
▪ Outpatient care	\$10 copayment/private visit; \$5 copayment/group visit No limit on visits	\$25 per visit; limited to 20 visits per calendar year (combined with non-severe mental health visits)
Prescription Drugs		
▪ Participating Network Pharmacy	Up to a 100-day supply Generic: \$5; Brand-name formulary: \$15	Up to a 30-day supply Generic: \$5; Brand-name formulary: \$15; Non-formulary: \$35; Home self-injectables: \$30
▪ Mail-Order Drug Service	Up to a 100-day supply Generic: \$5; Brand-name formulary: \$15	Up to a 90-day supply Generic: \$5; Brand-name formulary: \$15; Non-formulary: \$35

* Limits and benefits maximums do not apply to severe mental illness or serious emotional disturbances of children.

Blue Shield Spectrum PPO

	PPO Network	Out of Network**
Where You Go for Care	You may go to any provider in the Blue Shield PPO Network	You may go to any provider you choose
Calendar Year Deductible	\$200/person; \$600/family	
Calendar Copayment Maximum	None	\$1,000/person; \$3,000/family
Lifetime Maximum Benefit	\$6,000,000/person	
Covered Services	What You Pay	
Physician Office Visits	\$15 per visit	20% after deductible
Preventive Care (includes routine physicals and well-woman exams)	No copayment	20% after deductible
Well-Child Care (includes routine exams and immunizations)	No copayment	20% after deductible
Maternity (pre- and post-natal office visits)	No copayment after deductible	20% after deductible
Inpatient Hospital Services	No copayment after deductible	20% after deductible
Outpatient Surgery	No copayment after deductible	20% after deductible
Emergency Room Services	\$50 per visit (waived if admitted directly to the hospital)	
Physical, Occupational, or Speech Therapy	No copayment after deductible	20% after deductible
Chiropractic Care	No copayment after deductible Benefit limited to 24 combined visits per calendar year	20% after deductible
Acupuncture	No copayment after deductible Benefit limited to 24 combined visits per calendar year	20% after deductible
Durable Medical Equipment	No copayment Benefit limited to \$2,000 per calendar year	20% after deductible
Hearing Aids	20% after deductible; benefit limited to \$2,000 every 24 months	
Home Health Care	No copayment after deductible (prior authorization required); benefit limited to 100 combined visits per calendar year	
Skilled Nursing Facility	No copayment after deductible Benefit limited to 100 combined visits per calendar year	No copayment after deductible in a freestanding facility (prior authorization required)
Mental Health Services*		
▪ Inpatient Care	No copayment after deductible	20% after deductible
▪ Outpatient Care	\$25 per visit for non-severe conditions; \$10 per visit for severe conditions (no limit on visits) Benefit for outpatient non-severe mental health care limited to 20 visits per calendar year (combined with outpatient substance abuse visits)	20% after deductible; no limit on visits for severe conditions
Substance Abuse Services		
▪ Inpatient Care	Detoxification: no copayment after deductible; other inpatient care: 10% after deductible Hospital benefit limited to 30 days per calendar year	20% after deductible
▪ Outpatient care	\$25 per visit Benefit for outpatient substance abuse care limited to 20 visits per calendar year (combined with outpatient non-severe mental health visits)	20% after deductible
Prescription Drugs		
▪ Participating Network Pharmacy	Up to a 30-day supply Generic: \$5; Brand-name formulary: \$15; Non-formulary: \$35; Home self-injectables: \$30	Regular copayment plus 25% of the reasonable charge (as determined by Blue Shield) and any amounts exceeding the reasonable charge
▪ Mail-Order Drug Service	Up to a 90-day supply Generic: \$5; Brand-name formulary: \$15	Not covered

* Limits and benefits maximums do not apply to severe mental illness or serious emotional disturbances of children.

**Out-of-network benefits will be based on Blue Shield's allowable amount; you will be responsible for any charges above the allowable amount.

PRESCRIPTION DRUG BENEFITS

Blue Shield Pharmacy Benefits

The Blue Shield HMO and PPO plans provide prescription drug benefits at three different levels. Your copayment will vary depending on which category your prescription drug falls into: generic, formulary brand-name, or non-formulary brand-name. When you buy your drugs at a participating retail pharmacy, you'll get up to a 30-day supply for the copayments shown below.

- **Generic drugs (\$5)** 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 meet the same quality standards as the brand-name version. Generic drugs are your best value.
- **Formulary brand-name drugs (\$15)** are medications included on Blue Shield's list of preferred drugs. (This list is called a **formulary**.) These drugs are more expensive than generic drugs.
- **Non-formulary brand-name drugs (\$35)** are medications that are not included on Blue Shield's formulary. Many of the new drugs on the market—such as the ones you see advertised on television—would fall into this category.

If you decide you want a brand-name drug when a generic equivalent is available, you will have to pay the difference between Blue Shield's cost for the generic drug and the cost of the brand-name drug. However, if your doctor indicates that you must be given a brand-name drug (by writing "dispense as written" on your prescription), you will only have to pay the regular brand-name drug copayment.

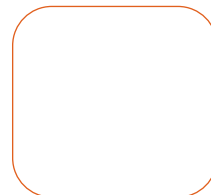
Self-administered injectable medications. Blue Shield dispenses these drugs through two specialty pharmacy networks, Caremark and Curascript. These drugs may require prior authorization from Blue Shield Pharmacy Services.



Kaiser Pharmacy Benefits

If you are a Kaiser member, you will have your prescriptions filled at a Kaiser pharmacy. Kaiser provides up to a 100-day supply of medication, either in its pharmacies or through mail-order, at the following levels:

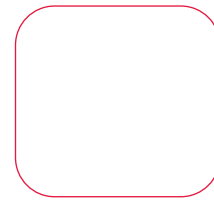
- **Generic drugs: \$5**
- **Brand-name drugs: \$15**



Blue Shield Mail-Order Drug Service

If you take maintenance medication — that is, drugs you take every day, like blood pressure or asthma medication — you can save time and money by filling your prescriptions through the mail.

DENTAL PLANS



New for 2009!

LACCD offers you the choice of two dental plans:

- Delta Dental PPO dental plan
- SafeGuard HMO dental plan

Delta Dental PPO

Like a medical PPO, this plan gives you the option of going to any licensed provider you choose. If you go to a dentist who is a member of Delta Dental's PPO network, you can take advantage of the PPO provider's discounted rates and reduce your out-of-pocket costs. Whenever you need dental care, you have three options, as shown below.

- 1. Delta Dental PPO dentists** — PPO dentists are a select group of dentists within the Delta Dental network, and they have agreed to charge plan members significantly reduced rates. *Delta Dental PPO dentists are your best value!*
- 2. Delta Dental Premier dentists** — These dentists belong to Delta Dental's extensive national network. Premier dentists accept Delta Dental's approved fee as payment in full, and your share of the cost (if any) will be based on the approved fee. This means they won't "balance bill" you for charges that Delta Dental doesn't cover.
- 3. Out-of-network dentists** — These dentists do not offer discounted rates to Delta Dental plan members. If you go to an out-of-network dentist, the plan will only pay benefits up to Delta Dental's approved fee. If your out-of-network dentist charges you more than the approved fee, you will have to pay the difference between their cost and the approved fee.



Let's Do the Math

Suppose you need a root canal, which the plan covers at 80%. Let's also assume that Delta Dental's approved fee for the root canal is \$500.* Here's an example of what you might pay for this service with each kind of dentist.

Delta Dental PPO Dentists. These dentists' fees have been set by Delta Dental, so their charge for this service is probably lower than the approved fee. Let's say your PPO dentist charges \$400 for a root canal.

- You would pay 20% of \$400, or \$80.

Delta Dental Premier Dentists. These dentists have agreed to accept Delta Dental's approved fee. This means they won't charge a Delta Dental member more than \$500 for this service, no matter what they might charge their non-Delta Dental patients.

- You would pay 20% of \$500, or \$100.

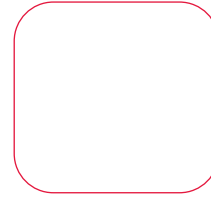
Out-of-Network Dentists. These dentists are not under contract with Delta Dental, so they're free to charge whatever they want. Let's say your out-of-network dentist charges \$700 for a root canal—Delta Dental's benefits will still be based on the approved fee of \$500. You will be responsible for the entire portion of the bill that exceeds Delta Dental's approved fee.

- You would pay 20% of \$500 (\$100), plus the \$200 above the approved fee, for a total of \$300.

As you see, a Delta Dental dentist (either Delta Dental PPO or Delta Dental Premier) is always your best bet—but you can save the most by going to a Delta Dental PPO dentist. Also, there are no claim forms to fill out when you go to a Delta Dental dentist. If you go to an out-of-network dentist, you may have to pay the entire cost up front, then submit a claim to Delta Dental to be reimbursed for the covered portion of your bill.

* The prices in this example do not reflect the actual costs for the procedure. Costs vary based on location and type of procedure performed. See your Evidence of Coverage for more information.

Remember, when you make an appointment with a Delta Dental dentist, be sure to ask if he or she is a Delta Dental PPO dentist — there is a difference!



Safeguard HMO Plan

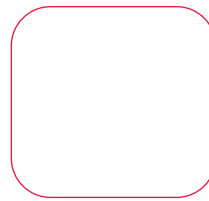
This plan provides services at little or no cost to you when you go to a dentist who is a member of the Safeguard HMO network. Similar to a medical HMO, the HMO dental plan requires you (and each of your enrolled dependents) to select a primary care dentist to coordinate your care. Out-of-network treatment is not an option.

The chart below shows the key benefits under your dental plans. Please refer to your Evidence of Coverage (available at www.laccd.edu/health) for complete information on the plan's benefits, limitations, and exclusions.



	SafeGuard HMO Dental Plan	Delta Dental PPO Plan
Calendar Year Deductible	None	None
Calendar Year Maximum Benefit	Unlimited	Your maximum benefit is based on how long you have worked for LACCD: <ul style="list-style-type: none"> • Less than 5 years of service = \$1,000 • 5 years of service, but less than 10 = \$1,500 • 10 years of service, but less than 15 = \$2,000 • 15 years of service, but less than 20 = \$2,500 • 20 or more years of service = \$3,000
Covered Services	What You Pay	
Diagnostic & Preventive Services (includes oral exams, cleanings once every 6 months, X-rays, fluoride treatments, and space maintainers)	No charge	20%
Basic Services (includes fillings, extractions, root canals, oral surgery, and periodontic treatment)	No charge	20%
Prosthodontics (includes crowns, bridgework, and dentures)	No charge	20%
Orthodontia	Children under age 19: \$1,300 Adults: \$1,400	50% Lifetime maximum orthodontia benefit = \$2,000/person

VISION PLAN



LACCD offers vision coverage through Vision Service Plan (VSP), the nation's largest provider of eye care coverage.

Under the vision plan, you can choose between network and out-of-network providers. You will receive a higher level of benefits, and enjoy greater convenience, if you go to a provider in the VSP network. VSP contracts with thousands of doctors across the country, so you should have no problem finding a network provider near you. There are no claim forms to fill out when you go to a VSP network provider.

If you decide to go to an out-of-network provider, you will have to pay your entire bill up front, then file a claim with VSP. You will be reimbursed for your out-of-network services up to the allowances shown in the chart below.

Supplemental Computer VisionCare Benefits (formerly know as VDT)

LACCD offers supplemental vision care benefits for active employees who work on a computer. If you qualify for these benefits, you will receive a computer vision eye exam to detect vision-related problems that can occur due to computer use. A separate pair of computer glasses may also be prescribed, if necessary. Applications for the Computer VisionCare benefits are available at www.laccd.edu/health. The application must be signed by your supervisor. Your Computer VisionCare benefits will be effective the first of the month after LACCD receives your approved application. This benefit is available only through a VSP network provider.

	VSP Network Provider	Computer VisionCare Supplemental Benefits	Out-of-Network Provider
Copayments			
▪ Exam & prescription glasses	\$10	\$10	None
▪ Contact lenses	None	None	None
Examination	Covered in full		Plan reimburses up to \$45
Prescription Lenses			
▪ Single vision	Covered in full, including anti-reflective coating	Covered in full	Plan reimburses up to \$45
▪ Lined bifocal			Plan reimburses up to \$65
▪ Lined trifocal			Plan reimburses up to \$85
▪ Lenticular			Plan reimburses up to \$125
Frame	Covered in full up to \$120*	Covered in full up to \$105*	Plan reimburses up to \$47
Contact Lenses (instead of glasses)**			
▪ Elective	Covered in full up to \$150	N/A	Plan reimburses up to \$150
▪ Medically necessary	Covered in full	N/A	Plan reimburses up to \$210
Covered Services	Examinations: once every 12 months; Lenses: once every 12 months Frame: once every 24 months; Contact Lenses: once every 12 months		



In addition, VSP members can receive a number of lens options (such as scratch-resistant coating and an additional pair of glasses) at a discounted price when using a VSP network provider. VSP has also arranged for members to receive PRK, LASIK, and custom LASIK using wavefront technology through contracted laser centers. Discounts vary by location (but average 15%). Contact VSP for details.

*If the frame you choose costs more than the allowance, you will receive a 20% discount on your out-of-pocket costs.

**Contact lenses are available once every 12 months in lieu of all other lens and frame benefits. When you get contact lenses, you will not be eligible for lenses or a frame for 12 months.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

If you have predictable health care or dependent day care expenses, the FSAs may be a good solution for you to pay for these expenses using tax-free dollars!

You may choose to set aside some of your pay into one or both FSAs before federal, Social Security (FICA), Medicare, or other taxes are withheld. This reduces your taxable pay, and you end up paying taxes on a smaller amount of income. Then, as you incur eligible out-of-pocket expenses, you can reimburse yourself for with money from your FSA. The money goes into your account untaxed, and remains untaxed when you receive it.

Making FSAs Work For You

The key to making FSAs work for you is to use your FSA for predictable expenses only—in other words, expenses you know you will incur during the 2009 plan year (January 1 – December 31, 2009).

- **Estimate Your Expenses Carefully Before You Enroll.** Calculate what you are likely to spend on health care and dependent care expenses during the plan year.
- **Make Contributions.** Your FSA contributions will automatically be deducted from your paychecks in equal amounts throughout the year.
- **Incur Your Expenses.** When you incur an eligible health care or dependent care expense, you will submit a claim form to the FSA plan administrator, SHPS. In some instances, it is not necessary for you to actually pay the bill before filing a claim for reimbursement—all that matters is that you have incurred the expense and it is not being reimbursed by any other source.



- **File for Reimbursement.** When you file a claim, you must include a copy of the receipt for paid medical or dependent care expenses or the explanation of benefits (EOB) form from your insurance company. To be reimbursed for over-the-counter medical expenses, include the store receipt with your claim form. The claims administrator, SHPS, will process your claim and send you a reimbursement check or, if you prefer, deposit the reimbursement directly into your checking account through electronic funds transfer (EFT). You must apply online for the EFT option.

Important FSA Rules

Because FSAs can give you a significant tax advantage, they must be administered according to specific Internal Revenue Service rules.

- **You must spend the money you put aside on expenses incurred during the 2009 plan year.** You will forfeit any money in your FSA accounts that is not used to pay eligible expenses incurred between January 1 and December 31, 2009. You have until March 31, 2010 to submit claims to SHPS.
- **Your FSA contributions will be in effect the entire plan year (January 1 – December 31).** You may only change your FSA contributions if you have a qualified life status change, such as marriage, divorce, or the birth of a child.
- **If you are currently enrolled in an FSA and wish to continue during the next plan year, you must re-enroll during annual enrollment.**



How to Enroll in an FSA

After determining how much you want to set aside, you're ready to enroll on the SHPS Web site. There is no paper enrollment.

- 1 Go to www.myshps.com between November 3 and November 26, 2008.
- 2 Click on the *Participants/Members* link.
- 3 Enter your last name, Social Security Number, and password (your password will be your date of birth, in MMDDYYYY format, until you change it).

- 4 Follow the instructions for enrolling in the Los Angeles Community College District's FSAs.
- 5 Print a copy of your enrollment election or request to receive your confirmation via e-mail.

When you enroll using the ESS portal, you will have the option of connecting to the SHPS Web site after you have printed out your confirmation statement and clicked on *Finish*.

An Overview of the Flexible Spending Accounts

	Health Care FSA	Dependent Care FSA
How Much You Can Contribute Each Plan Year (January 1 - December 31)	Up to \$5,000	Up to \$5,000, depending on your marital and tax-filing status
Who Can Incur Eligible Expenses	Your FSA covers you, your legal spouse, and your dependent children – even if you do not cover them under any health care plans.	<ul style="list-style-type: none"> ■ Your children age 12 or younger who live with you as a claimed dependent on your federal income tax return ■ Anyone over age 12 whom you claim as a dependent on your federal tax return – including your spouse or elderly parent – who needs care due to a physical or mental disability
	You may not use your FSA to pay expenses incurred by your domestic partner (or your domestic partner's child) unless that person qualifies as a "tax dependent" under Internal Revenue Code Section 152. A person generally would qualify as a tax dependent if you provide more than 50% of that person's support; the person lives with you for the entire calendar year; the person is a U.S. citizen or resident; and the person's relationship with you does not violate any local laws. Consult your tax adviser regarding your domestic partner's tax status.	
Examples of Eligible Expenses A complete list of eligible expenses is provided in IRS Publications 502 and 503, available at www.irs.gov	Your share of medical, prescription, dental, and vision care expenses, such as: <ul style="list-style-type: none"> ■ Deductible, copayments, and coinsurance ■ Orthodontia ■ Prescription eyeglasses and sunglasses, contact lenses, and lens solution ■ Laser eye surgery ■ Nonprescription medications and drugs, such as pain relievers, antacids, and allergy and cold medicines 	Child day care or elder care so that you – and your spouse, if you are married – can work <ul style="list-style-type: none"> ■ Dependent care provided inside or outside your home ■ Care at licensed pre-school facilities, nursery schools, day camps (not overnight camps), or day care centers for dependent adults or children ■ Before- and after-school care ■ A portion of a housekeeper's services that includes providing care for your eligible dependent
Examples of Ineligible Expenses	<ul style="list-style-type: none"> ■ Services that are not medically necessary (like cosmetic surgery) ■ Nonprescription products used for general health (like vitamins, diet supplements, or toothpaste) ■ Expense that will be reimbursed by another source 	<ul style="list-style-type: none"> ■ Food, clothing, education (including kindergarten and higher grades) ■ Payments to your spouse, parent, or dependent child under age 19 ■ Care provided during nonworking hours
Reimbursement for Your Expenses	You can be reimbursed up to the full amount of the annual health care FSA contribution you elected – even if all of the money has not yet been deposited into your account.	You will be reimbursed up to the current account balance; future reimbursements are available as additional money is deposited to your account.
Claim Filing Deadline	March 31 for expenses you incur during the preceding plan year	

LIFE AND ACCIDENT INSURANCE

All active full-time employees are automatically covered by the basic life insurance and basic accidental death and dismemberment (AD&D) insurance plans. LACCD pays the full cost of these plans, which are insured by MetLife.

Basic Life Insurance

If you die while covered under the basic life insurance plan, your beneficiary will receive your basic life insurance benefit of \$50,000.

Basic AD&D Insurance

This plan pays an additional benefit, equal to your basic life insurance amount (\$50,000), if you die as a result of a covered accident. Benefits are also payable if you suffer certain severe injuries in an accident, including loss of a limb, loss of sight, or paralysis.

Voluntary Life Insurance

Additional coverage for you. You may purchase optional life insurance in \$10,000 increments, up to a maximum benefit of five times your annual earnings or \$500,000, whichever is less. You may purchase up to \$120,000 worth of coverage without answering any medical questions. If you choose to purchase more than \$120,000 in voluntary life insurance, you will be required to give MetLife satisfactory evidence of good health before the coverage over that amount will become effective. You will pay the full cost of your voluntary life insurance coverage through after-tax payroll deductions.



Coverage for your family. If you purchase voluntary life insurance for yourself, you may also purchase coverage for your spouse/domestic partner and your dependent children. You will pay the full cost of your family members' coverage through after-tax payroll deductions.

- **Spouse/domestic partner.** You may purchase coverage in \$5,000 increments, up to a maximum benefit of 50% of your voluntary life insurance amount.
- **Children.** You may purchase \$1,000, \$5,000, or \$10,000 worth of coverage for your dependent children. For children who are less than six months old, the benefit amount is \$100. A single premium is charged for child coverage regardless of how many children you have.

Designating a beneficiary. Your beneficiary is the person you name to receive benefits under these plans if you pass away. To be certain your loved ones are taken care of in the event of an unforeseen loss, it's important that you name a beneficiary when you enroll for benefits. Your beneficiary does not have to be your dependent; you may designate anyone you choose (including charitable organizations). Also, if you have a change in your family situation, such as marriage or divorce, don't forget to think about whether it affects who you want as your beneficiary.



EMPLOYEE ASSISTANCE PROGRAM (EAP)

Everyone needs help now and then. Whether it's a difficult situation affecting your home life or stress interfering with your work, the employee assistance program (EAP) is there for you and all members of your household 24 hours a day. The EAP is provided by LACCD at no cost to you and is administered by Horizon Health.

The EAP provides strictly confidential counseling through outside professionals to help you manage stress and resolve personal issues that may be affecting your daily life. The EAP can help you with:

- Emotional well-being
- Marriage and family issues
- Child care and elder care referrals
- Stress/anxiety
- Grief counseling
- Depression
- Alcohol or drug abuse
- Workplace conflict
- Legal assistance
- Educational referrals
- Financial consultation



Call the EAP at the number shown below whenever you need help. Your call will be handled confidentially by a professional counselor, who will either work with you over the phone or arrange an appointment for you to have an in-person session. The EAP will cover up to five free face-to-face counseling sessions for each issue per year.

For 24-Hour EAP Help, Call (800) 342-8111





Joint Labor/Management Benefits Committee

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Chair, JLMBC

Robert Garber

*Management Representative
President, Pierce College*

Dawn Bastin

Director, LACCD Business Services

Velma J. Butler

*President
AFT College Staff Guild
Local 1521A*

Frank Torres

SEIU Local 99

Royston Thomas

Teamsters Local 911

Violet Amrikhas

SEIU Local 721

Ted Strinz

*Building & Construction
Trade Council*

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OUR MISSION

The mission of the Joint Labor/Management Benefits Committee is to select and review the District's health benefit plans and providers to contain costs while maintaining the quality of the benefits available to employees. The cooperation between representatives of labor and management has resulted in the ability of our employees to enjoy an outstanding benefits program.