Return to Benefits

Los Rios Community College District

Adjunct
Medical Insurance

Plans Available

- Health Net HMO Health Plan
- Health Net PPO Health Plan
- Kaiser Foundation Health Plan
- PacifiCare Health Plan
- BenElect Voluntary Benefit Plans

Eligibility

Those eligible to participate in the district medical plans include:

A. Adjunct faculty members deemed eligible per terms of the LRCFT Collective Bargaining Contract. The following enrollment requirements must be met:

- Must qualify as a member of the certificated employee unit (LRCFT), have taught two of the last five semesters (summer sessions not included) and have a Tentative Class Schedule (TCS) for the current semester.
- Must complete all of the enrollment procedures described in the LRCFT contract.
- Must be working on September 1 or March 1 of each academic year based upon an approved and processed Tentative Class Schedule providing for a total of at least 30% of full time (.300 FTE) or 4.5 formula hours.
- Workload assignments of other types (i.e. Employment Service Agreements, Personal Service Agreements, etc.) do not create FTE for medical and dental benefits.

B. Dependents, as defined by medical insurance plans, include:

- The employee's spouse.
- A dependent child of the employee or employee's spouse who is both unmarried and under age 19.
- An unmarried dependent child of the employee or employee's spouse who is between the ages of 19 and 24 and a full-time student.
- Either you or your spouse's/domestic partner's dependent children may continue to be covered beyond the group's limiting age if they are incapable of self-sustaining employment because of total disability (as defined by the carrier). The disability must have occurred prior to the limiting age and must be chiefly dependent upon you or your spouse/domestic partner for support and maintenance.

Return to Benefits

C. Employee's domestic partner and children of domestic partner.

Enrollment Period and Procedures

You must certify on form #114 at the time of initial enrollment that you do not have other medical coverage. If you are a participant in a District insurance plan and become covered by another plan as an employee, spouse or dependent and that coverage is either fully paid or partially paid by another employer, you shall immediately become ineligible under the District plan. You must notify the Employee Benefits Department within 30 days if such coverage exists.

The Employee Benefits Department will confirm all Tentative Class Schedules on file with the Human Resources Department as of (a) August 23 (for benefits beginning September 1) and (b) February 10 (for benefits beginning March 1). The Employee Benefits Department will notify the faculty member of their qualifying FTE if there are any premium changes. If this FTE is incorrect, the adjunct faculty member must notify the Employee Benefits Department and provide copies of the Tentative Class Schedules showing the correct FTE within 10 calendar days after the District mails the original notice to the employee.

It is the employee's responsibility to enroll newborn children, adopted children, new spouses and other dependent children within 31 calendar days of birth, adoption or marriage.

Joint District Medical Insurance Program

Eligible faculty who plan to participate in the District medical program and also teach credit courses at Sierra Community College District may include such courses to qualify for Los Rios medical benefits, if the combined credit workload is equal to or greater than 60% of full-time (.60 FTE), thus reducing the employee cost of medical insurance.

The joint District program applies to medical insurance benefits only. The joint District program does not apply to dental benefits.

You must file form CCFS-361 with the District, certifying all credit courses taught at both Districts, by August 23 (for Fall semester benefits) and February 10 (for Spring semester benefits.)

Premium Payments and Summer Coverage

Premium payments vary by medical plan selected, and will be deducted over a five-month period, but provide 6 months of coverage for those employees working only one semester. Premium payments will be deducted on a tenthly basis over a ten month period for those employees working the Fall and Spring semesters consecutively. Coverage will

be as follows:

- For employees working under contract for both the Fall and Spring semester, the coverage period is from September 1st through August 31st. (12 months)
- For employees working under contract for only the Fall semester, the coverage period is from September 1st through February 28th. (Six months)
- For employees working under contract for only the Spring semester, the coverage period is from March 1st through August 31st. (Six months)
- To determine your portion of the premium for medical and/or dental insurance please use the **Premium Calculator**.

Termination of Coverage

The medical coverage will be canceled by the District upon termination of employment; however, you may be eligible to continue your medical coverage for up to 18 months by self-paying the premiums.

If there is a break in coverage, you will be eligible to reenroll in District medical plans only if you elected COBRA coverage upon conclusion of previous employment with the District and have continued that coverage to the beginning of the new employment period (Tentative Class Schedule). Employees who did not elect and continue COBRA coverage will be ineligible for coverage or District contribution for a minimum of eighteen months after the last day in paid status.

Domestic Partners

Employees may enroll domestic partners and eligible children of domestic partners in a medical plan within 31 calendar days of submitting a notarized **Affidavit of Domestic Partnership**, or within 31 calendar days of adoption or birth.

Under applicable federal and state income tax law, payments for medical coverage for a domestic partner are not eligible for pre-tax treatment. In addition, coverage of the domestic partner will result in additional imputed taxable income to the employee. If domestic partners and/or their dependents meet the definition of a dependent under section 152 of the IRS code, the value of their medical/dental insurance is exempt from imputed income. You may want to contact your tax advisor for guidance if you believe you might be exempt from imputed income.

Effective January 1, 2002, California law exempts you from paying State income tax on *imputed income* related to medical premiums if you have filed a Declaration of Domestic Partnership with the California Secretary of State, and either of the two following conditions are met: (1) you and your partner are of the same sex or 2) either you or your partner is over 62 and meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) or Section 1381.

Return to Benefits

If you have already filed a declaration with the Secretary of State, please forward a filed copy to the Employee Benefits Department and we will adjust your State taxable income accordingly. If you have not filed a declaration, but are eligible and wish to do so, you can download the form from the Secretary of State's website, **www.ss.ca.gov,** (under "Special Programs Information") and follow the directions printed on the form.

Please refer to the **domestic partner** section of this site for detailed information regarding the District's domestic partner policies and procedures.

Important Eligibility and Coverage Information

Normally you cannot change medical plan elections in which you participate during a calendar year, except at the beginning of each Fall or Spring semester.

An exception would be by reason of a Qualifying Family Status Change event. Acceptable Family Status Changes are listed below. You have 31 calendar days from the date of your qualifying event to notify the Employee Benefits Department and submit the required forms.

Qualifying Family Status Changes
Marriage, divorce, legal separation, or death of your spouse or domestic partner
Birth, adoption or death of your dependent child or domestic partner's child
Change in your dependent child's status or the child of your domestic partner (student eligibility; marriage; etc.)
Termination or commencement of your spouse's employment
A significant change in health coverage provided by your spouse's employer that affects you or your spouse
You enter or end a domestic partnership
Your dependents have moved into, or out of, the service area
You change from part-time to full-time status, or vice versa

If you have a Qualifying Family Status Change, you can revise your benefits only in ways that are consistent with that change. For instance, if one of your covered children is no longer a full-time student, you would delete her/him from your coverage, but you would not be eligible to change any other dependent's coverage or your own coverage. **Your written request to make plan changes must be received by Employee Benefits within 31 calendar days of the qualifying event.**

Return to Benefits

Premiums

Premiums will vary based upon your FTE for a given semester and whether or not you are also teaching at Sierra College. We do not have a tiered rate structure at Los Rios. All of the medical plans are family plans. There is no additional cost to cover eligible dependents. Please contact the Employee Benefits Department for specific premium information. Please make certain you know your FTE for the semester before calling Employee Benefits.

Out-of-pocket premium costs are deducted from gross wages **before** taxes are calculated.

COBRA

COBRA continuation benefits may be available if you and/or your dependents lose coverage due to termination of employment, reduction in hours, divorce, legal separation or dependent ineligibility. The Los Rios Employee Benefits Department must be notified in writing within sixty (60) days of the date of the later of the qualifying event or the date on which coverage would end under the plan because of the qualifying event.

In the event of an employee's termination of employment or death, the Los Rios Employee Benefits Department will inform the employee or qualified beneficiary of their right to continue coverage. Qualified beneficiaries will have sixty (60) days from the date they lose coverage because of a qualifying event to inform the Los Rios Employee Benefits Department in writing that they want COBRA continuation coverage.

Note: Refer to the COBRA section of this site for a detailed description of COBRA continuation benefits.

Return to Benefits

MEDICAL PLANS

Kaiser
Health Net HMO
Health Net PPO
PacifiCare

Kaiser (Group #233)
Member Services – (800) 464-4000

Kaiser is a health maintenance organization (HMO) providing comprehensive health care. You must reside within an eligible service area zip code to qualify for enrollment. Visit **http://www.kaiserpermanente.org/locations/california/locations/index.html**, contact Member Services or the Employee Benefits Department for a list of eligible zip codes. Members must utilize Kaiser facilities and Kaiser physicians unless it is an emergency (as defined by Kaiser). Standard copayments are $15 for office visits and $10 for each prescription. Please refer to the **schedule of prepayment fees** for additional copayment/coverage information.

Selecting a Primary Care Physician
As a member of Kaiser, you are encouraged to choose a personal physician(s) for yourself and covered dependents. You may select personal plan physicians from the following specialties: internal medicine, obstetrics/gynecology, family practice and pediatrics. To select or change a personal physician, contact Kaiser Member Services at the number listed above. If you do not select a physician beforehand, Kaiser will assign a physician the first time you call to schedule an appointment.

Terms & Conditions
Your participation and the benefits to which you are entitled under the Kaiser Health Plan are subject to the terms and provisions of the plan as defined by Kaiser and/or the respective **collective bargaining agreement** or **District policies**. This description of the Kaiser Health Plan is general in nature and does not fully describe all of the terms and conditions of this plan. To obtain a more detailed description of the plan, contact Kaiser or the Employee Benefits Department. You may also visit Kaiser's web site at **http://www.kaiserpermanente.org/.**

Return to Benefits

Kaiser Schedule of Prepayment Fees
Group #233

BENEFIT	DESCRIPTION	CO-PAYMENT
In The Hospital	All physician and surgeon services	No Charge
	Intensive care/Cardiac Care	No Charge
	Room and board	No Charge
	Laboratory and X-ray	No Charge
	Physical therapy (short-term)	No Charge
	Other necessary services and supplies (including special nursing and administered medications)	No Charge
In The Doctor's Office	Allergy test and injection visits	$3 Per Visit
	Physical therapy visits (short term)	$15 Per Visit
	Laboratory and X-ray	No Charge
	Office visits (includes routine physical exams, well-baby check-ups, OB/GYN appointments and hearing and vision examinations)	$15 Per Visit
Maternity Care	Scheduled prenatal care & first postpartum visit	$5 Per Visit
	Hospital services	No Charge
	Complications of pregnancy	No Charge
Prescription Drugs	Obtained at Plan pharmacies (up to a 100-day supply for generic and prescribed, medically necessary brand name drugs)	$10
Durable Medical Equipment	Covered DME according to Kaiser formulary	No Charge
Extended Care	Up to 100 days per calendar year of prescribed care in a skilled nursing facility	No Charge
Mental Health Care	Office Visit-Up to 20 visits per calendar year when prescribed by a Plan physician Individual visit Group Visit	 $15 Per Visit $7 Per Visit
	Hospitalization-Up to 45 days of inpatient care per calendar year	No Charge
Alcohol or Drug Dependency Care	Office visits: Individual Group	 $15 Per Visit $5 Per Visit
	Inpatient detoxification Transitional residential recovery services (up to 60 days per calendar year)	No charge $100 per admission

Return to Benefits

Health Net HMO (Group #F5910A)
Member Services – (800) 522-0088

Health Net is a health maintenance organization providing comprehensive health care. You must live within an eligible service area zip code to qualify for enrollment. You may contact Health Net Member Services or the Employee Benefits Department for a list of eligible zip codes.

Selecting a Primary Care Physician
As a member of Health Net Health Plan, you are required to select a primary care physician from the participating provider directory. A copy of the directory may be obtained from Health Net, from the District Office Employee Benefits Department or you may visit the Health Net web site at **http://www.healthnet.com/** for up-to-date directory information. If you do not select a physician when you enroll, Health Net will select one for you. Each family member may choose his/her own primary care physician. Your primary care physician, when necessary, will refer you to a Health Net specialist by issuing a referral form called an Authorization for Consultant's Services. This form lists the type of care or services that you need and the number of visits that you can schedule. Self-referrals are allowed for Obstetrician and Gynecological services.

You may switch doctors within the same physician group at any time. You may also transfer to another physician group monthly. Contact Health Net by the 15th of the month to have your transfer effective by the 1st of the following month. If you call after the 15th, your transfer will be effective the 1st of the next month, or an additional 30 days later.

Co-payment/Prepayment Fees
Standard copayments are $15 for office visits, $10 for generic prescription drugs and $20 for brand name prescription drugs included in Health Net's Formulary. Health Net's new Pharmacy Benefit Plan now offers a $35 non-Formulary benefit under which members pay a $35 co-payment when the drug is not on the Health Net Drug Formulary. If a brand name drug is requested by a member when a generic equivalent is commercially available, the co-payment is $35 plus the difference in cost between the brand name drug and the generic equivalent. However, if the Prescription Drug Order states "do not substitute" or "dispense as written," in the physician's handwriting, only the non-formulary brand name drug co-payment will apply. Please refer to the **schedule of prepayment fees** for additional co-payment/coverage information.

Terms & Conditions
Your participation and the benefits to which you are entitled under the Health Net Health Plan is subject to the terms and provisions of the plan as defined by Health Net and/or the respective **collective bargaining agreement** or **District policies**. This description of the Health Net Health Plan is general in nature and does not fully describe all of the terms and conditions of this plan. To obtain a more detailed description of the plan, contact Health Net or the Employee Benefits Department.

Return to Benefits

Health Net HMO Schedule of Prepayment Fees
Group #F5910A

BENEFIT	DESCRIPTION	CO-PAYMENT
In The Hospital	All physician and surgeon services	No Charge
	Intensive care/Cardiac Care	No Charge
	Room and board	No Charge
	Laboratory and X-ray	No Charge
	Physical therapy (short-term)	No Charge
	Other necessary services and supplies (including special nursing and administered medications)	No Charge
In The Doctor's Office	Allergy test and injection visits	No Charge
	Physical therapy visits (short term)	$10 Per Visit
	Laboratory and X-ray	No Charge
	Office visits (includes routine physical exams, well-baby check-ups, OB/GYN appointments and hearing and vision examinations)	$10 Per Visit
Maternity Care	Physician and paramedical office visits	$10 Per Visit
	Hospital services	No Charge
	Complications of pregnancy	No Charge
Prescription Drugs	Obtained at Plan pharmacies (up to a 30-day supply for generic and prescribed, medically necessary brand name drugs)	$5, $10 or $35
Ambulance Service	Authorized by a Plan Physician	No Charge
Extended Care	Up to 60 days per calendar year of prescribed care in a skilled nursing facility	No Charge
Mental Health Care	Office Visit-Up to 20 visits per calendar year when prescribed by a Plan physician	$30 Per Visit
	Hospitalization-Up to 30 days of inpatient care per calendar year	No Charge
Alcohol Or Drug Dependency Care	Office visits	$30 Per Visit
	Hospitalization-detoxification and impatient chemical dependency (30 days)	No Charge

Return to Benefits

Health Net PPO (Group # 29196A)
Member Services – (800) 522-0088

A Preferred Provider Organization (PPO) is a form of managed care, but it is similar to a traditional "fee-for-service" plan. PPO's contract with doctors, hospitals and other providers of health care to provide services for an agreed upon charge. Unlike an HMO, where a primary care physician directs all of your care, a PPO allows you to select a provider, and a specialist, without referral. You have freedom of choice to select the physician or hospital of your choice, as long as you are in the group plan.

Level of Coverage
Basically, Health Net's PPO provides two levels of coverage, "In-Network" and "Out-of-Network." If you select a physician or hospital from within Health Net's network, your out-of-pocket costs will be lower because these providers have agreed in advance to provide services for a specific fee. If you are utilizing providers outside the network, you will be responsible for the applicable copayments or coinsurance, plus payments of any charges that Health Net considers excessive. Certain services require "certification," or prior approval, to ensure that you receive full benefits under the plan. These services are listed in Health Net's *Summary of Benefits* brochure, available from the Employee Benefits Department.

Pre-Existing Conditions
Unlike our HMO contracts, Health Net's PPO plan imposes a pre-existing conditions exclusion on medical conditions for which the employee, or any dependent, has been treated during the six-month period prior to enrollment. A pre-existing condition is a medical condition, illness or injury for which a member received care or advice within six months prior to enrolling in the plan. The pre-existing conditions clause would be waived if the employee or dependent were covered by a medical plan for the immediate prior six months preceding enrollment. If you were covered under Creditable Coverage, the time spent under the Creditable Coverage will be used to satisfy or partially satisfy the 6-month period during which the Pre-existing Condition limitation applies.

Participating Physicians
A copy of the PPO directory of physicians may be obtained from Health Net, from the District Office Employee Benefits Department, or you may visit the Health Net web site at **www.healthnet.com** for up-to-date-directory information. Please refer to the **schedule of prepayment** fees for additional copayment/coverage information.

Terms & Conditions
Your participation and the benefits to which you are entitled under the Health Net Health Plan is subject to the terms and provisions of the plan as defined by Health Net and/or the respective **collective bargaining agreement** or **District policies**. This description of the Health Net Health Plan is general in nature and does not fully describe all of the terms and conditions of this plan. To obtain a more detailed description of the plan, contact Health Net or the Employee Benefits Department.

Return to Benefits

Health Net PPO Schedule of Prepayment Fees
Group #29196A

Plan Benefits	Health Net Plan 2U	
	In-Network	Out-of-Network
Lifetime Maximum	$5,000,000	
Deductibles	$250 individual/$750 family	
Out-of-Pocket Maximum	$3,000	$5,000
Doctor Visit	$15 *(deductible waived)*	70% Limited Fee Schedule [1]
Inpatient Hospitalization/Supplies	10%	70% of Max. Allowed *($600/day max.)*
Outpatient Surgical/Dr. Svcs	10%	70% of Max. Allowed
Inpatient Maternity/Dr. Svcs	10%	70% Limited Fee Schedule [1]
Outpatient Maternity/Dr. Svcs	10%	70% Limited Fee Schedule [1]
Substance Abuse – Inpatient *Detoxification & Rehabilitation*	10% *($175 max./20 day limit)*	70% of Max. Allowed [2]
Substance Abuse – Outpatient	10% *($25/20 day limit)*	70% Limited Fee Schedule [1,2]
Mental Health – Inpatient	10% *($175 max./20 day limit)*	70% of Max. Allowed [1]
Mental Health – Outpatient	10% *($25/20 day limit)*	70% Limited Fee Schedule [1,2]
Skilled Nursing Facility	10% *+ Per admit deductible $250*	70% of Max. Allowed *($250 max.)*
Short-Term Therapy ***Physical, Speech, Occupational***	10% *12 visits cal. yr.*	70% Limited Fee Schedule [2] *$25 Max./per visit*
X-Ray, Lab Diagnostic Svcs	10%	70% Limited Fee Schedule [2]
Durable Medical Equipment	10%	70% Limited Fee Schedule [2]
	$2,000 per year maximum	
Emergency (ER) Care *Copay Waived if Admitted – Yes or No*	$100 co-pay + 10% *Yes ($100)*	10% of Covered Expense
Rx Drugs Walk-In Generic Brand Name Non-formulary	$5 (30 day supply) $10 (30 day supply) 50%	
Rx Drugs Mail Order Generic	$10 (90 day supply)	Not Available
Brand Name	$20 (90 day supply)	

[1] Does not count towards Copayment maximum

[2] Limited Fee Schedule: 75% of RBRVS (Resource Based Relative Value System) amounts, Hospital Inpatient max. $600/day, Outpatient Hospital 50% of billed charges.

Return to Benefits

PacifiCare (Group #100807)
Member Services (800) 624-8822

PacifiCare is a Health Maintenance Organization (HMO) providing comprehensive health care. You must live within an eligible service area zip code to qualify for enrollment. You may contact PacifiCare Member Services or the Employee Benefits Department for a list of eligible zip codes.

Selecting a Primary Care Physician
As a member of PacifiCare Health Plan, you are required to select a primary care physician from the participating provider directory. A copy of the directory may be obtained from PacifiCare, the Employee Benefits Department, or you may visit the PacifiCare web site at **www.pacificare.com** for up-to-date directory information. Each family member must choose his/her own primary care physician. Your primary care physician, when necessary, will refer you to a PacifiCare specialist. If you do not select a physician when you enroll, PacifiCare will select one for you.

If your request is received on or before the 15th of the month, PacifiCare will change your participating medical group or primary care physician effective the first day of the following month. If PacifiCare receives your change request after the 15th of the month, the change will be effective the first day of the second month.

Co-payments & Prepayment Fees
Standard copayments are $10 for office visits, $5 for generic prescription drugs and $10 for brand name formulary prescription drugs. Non-Formulary prescription drugs are only available if they have been pre-authorized by PacifiCare. Please refer to the **schedule of prepayment fees** for additional co-payment/coverage information.

Terms & Conditions
Your participation and the benefits to which you are entitled under the PacifiCare Health Plan are subject to the terms and provisions of the plan as defined by PacifiCare and/or the respective **collective bargaining agreement** or **District policies**. This description of the PacifiCare Health Plan is general in nature and does not fully describe all of the terms and conditions of this plan. To obtain a more detailed description of the plan, contact PacifiCare or the Employee Benefits Department.

Return to Benefits

PacifiCare Health Plan Schedule of Prepayment Fees
Group #100807

BENEFIT	DESCRIPTION	CO-PAYMENT
In The Hospital	All physician and surgeon services	No Charge
	Intensive care/Cardiac Care	No Charge
	Room and board	No Charge
	Laboratory and X-ray	No Charge
	Physical therapy (short-term)	No Charge
	Other necessary services and supplies (including special nursing and administered medications)	No Charge
In The Doctor's Office	Allergy test and injection visits	$5 Per Visit
	Physical therapy visits (short term)	$10 Per Visit
	Laboratory and X-ray	No Charge
	Office visits (includes routine physical exams, well-baby check-ups, OB/GYN appointments and hearing and vision examinations)	$10 Per Visit
Maternity Care	Physician and paramedical office visits	$10 Per Visit
	Hospital services	No Charge
	Complications of pregnancy	No Charge
Prescription Drugs	Obtained at Plan pharmacies (up to a 34-day supply for generic and prescribed, medically necessary brand name drugs)	$5 or $10
Ambulance Service	Authorized by a Plan Physician	No Charge
Extended Care	Up to 100 days per calendar year of prescribed care in a skilled nursing facility	No Charge
Mental Health Care	Office Visit-Up to 20 visits per calendar year when prescribed by a Plan physician	$10 Per Visit
	Hospitalization-Up to 20 days of inpatient care per calendar year	No Charge
Alcohol Or Drug Dependency Care	Office visits-detoxification only	No Charge
	Hospitalization-detoxification only	No Charge

BenElect Voluntary Benefit Plans
Member Services (877) 214-0022

If you do not qualify for the preceding benefit programs, you may want to consider enrolling in a benefit plan through BenElect. BenElect has four different plans to choose from, depending on yours and your family's health care needs. There are different levels of benefits within each plan, and some plans contain waiting periods and pre-existing condition requirements. All plans provide affordable coverage, and utilize a large, national Preferred Provider Organization (PPO) network in order to contain costs.

Although sponsored by FACCC, the Faculty Association of California Community Colleges, membership in FACCC is not required.

This program is available only by employee enrollment and payment through this website:

http://FACCC.BenElect.myternian.com

For more information regarding the different plan types- deductibles, co-pays, etc please check out the brochure located here:

BenElect Brochure

Return to Benefits