



# Faculty Association Art. 10.2 Supplemental Benefits

(Submitting Your Claim)

Office of Human Resources

# Fund vs. Section 125

- You reserve pre-tax income for medical expenses in a Section 125 account.

*Use it during the calendar year or “Lose it”.*

- Art. 10.2 Is Not Section 125



# Who is eligible\*?

- Eligible faculty members who
  - Switched coverage from PERS *Care* to PERS *Choice* health care plan during the 2012 open enrollment period
  - Had PERS *Care* in 2012 and switch to PERS *Choice* in a *subsequent* year
  - Had PERS *Choice* in 2012
  - Are receiving early retirement supplemental benefits as of Jan. 01, 2013

\* *Faculty personnel and their eligible dependents*

# What is eligible for reimbursement?

- Eligible out-of-pocket medical expenses in excess of \$250 in any calendar year
- Expenses incurred due to exceeding maximum coverage levels under *Choice* that would have been covered by *Care*
- Incurred by eligible faculty member and eligible dependents
- Medicare expenses



# What is NOT eligible for reimbursement?

- Deductibles
- Copayments
- Out-of-pocket maximums
- Reimbursement of service provided by a non-PPO provider (out-of-network) *shall be limited* to amount that would have been incurred had the service been provided by a PPO provider (in-network provider).



# Maximum Amount of Reimbursement

The maximum amount varies depending on the category of expenditure (also known as a “benefit” or “category”).

Examples of a benefit, or category:

- Chiropractic
- Acupuncture
- Physical Therapy
- Skilled Nursing Care



# The Paperwork

- You will need the following forms/documents to submit a claim for reimbursement:
  - Faculty Association Art. 10.2 Supplemental Benefit Claim Form
  - Comparison Chart of PERS *Care* vs. PERS *Choice* for Plan Year
  - Supporting documentation

*NOTE: Make sure that the Claim Form and Comparison Chart are all for the same plan year in which expenses were incurred*

Click on the following link to find the forms and guidelines on the HR website:

<http://www.smc.edu/HumanResources/HumanResourcesDepartment/Pages/FA-Supplemental-Benefits-Fund.aspx>

# Claim Form



Print your contact information



Read



Sign your name



Out-of-Pocket Amount:  
Fill in total dollar amount of incurred expenses (from Worksheet)



Date your signature



Follow instructions on following pages

	OFFICE OF HUMAN RESOURCES <b>FACULTY ASSOCIATION AGREEMENT</b> <b>ARTICLE 10.2 SUPPLEMENTAL BENEFIT</b> <b>REIMBURSEMENT CLAIM FORM</b> <b>2015 PLAN YEAR</b>			Copies to: <input type="checkbox"/> Employee <input type="checkbox"/> HR <input type="checkbox"/> Fiscal		
	<p>* Per Article 10.2.1 of the SMFA-SMCCD Agreement: "The...provision shall apply to: (a) any faculty member who switches coverage from PERScore to PERS Choice during the 2012 open enrollment period; (b) any faculty member who had PERScore in 2012 and switches to PERS Choice in a subsequent year; (c) any faculty member who had PERS Choice in 2012; and (d) to any retired faculty member receiving early retiree supplemental benefits as of January 01, 2013."</p>					
<b>PART 1: FACULTY MEMBER CONTACT INFORMATION</b>						
Last, First Name (Please Print or type):				Tel. No.:		
Discipline/Department:			Email Address:			
Mailing Address:		City:	State:	Zip Code:		
<b>PART 2: OUT-OF-POCKET MEDICALLY ELIGIBLE EXPENSES:</b>						
	Date of Service (dd/mm/yy)	Patient Name	Provider Name	Description of Service	Out-of-Pocket Amount	Amount Approved By SMC
1.					\$	\$
2.					\$	\$
3.					\$	\$
4.					\$	\$
5.					\$	\$
6.					\$	\$
7.					\$	\$
8.					\$	\$
Complete another form if needed.				Medicare Eligible? Yes <input type="checkbox"/> No <input type="checkbox"/>	Total Claim: \$	
<b>IMPORTANT INFORMATION</b>						
1. <b>Documentation must be submitted</b> to prove out-of-pocket expenses and that such expenses were paid. Documentation includes: <ul style="list-style-type: none"> <li>Explanation of Benefits (EOB) statement from insurance carrier; <b>AND</b></li> <li>Itemized statement from your provider that indicates the name of provider, patient name, cost, date of service, description of service, and your amount paid to provider <b>OR</b> Proof of Payment Receipt – receipt of out-of-pocket expenses you paid to the provider.</li> </ul>						
2. If additional space is needed to explain expenses listed above, please use Page 2.						
3. District <i>may</i> request additional information as needed.						
In signing my name below, I am requesting reimbursement for items listed above in accordance with Article 10.2 of the SMFA-SMCCD Agreement and hereby certify that the amounts claimed on this form are monies I actually expended for eligible out-of-pocket medical services per Article 10.2 and are not covered by my PERS Choice coverage. I understand that fraudulent claims for reimbursement may result in disciplinary and/or legal action.						
SIGNATURE OF CLAIMANT (or designee):				DATE:		
Submit Claim Form and Supporting Documentation To: Office of Human Resources By Mail - 1900 Pico Blvd., Santa Monica, CA 90405 In-Person - 2714 Pico Blvd. 2 <sup>nd</sup> Floor, Santa Monica, CA 90405						
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# Comparison Chart

## Active Employees



Are you an active employee? Use this chart

Santa Monica College  
Comparison of PERScare and PERS Choice for SMCFA-SMCCD Art. 10.2  
**Non-Medicare Coverage**  
**2015 Plan Year**



Check Plan Year

Deductibles Copayment/Coinsurance	PERScare Member Pays		PERS Choice Member Pays	
Calendar Year Deductibles	\$500	Member	\$500	Member
	\$1,000	Family	\$1,000	Family
Maximum Calendar Year Copayment/Coinsurance Responsibility	\$2,000	Member	\$3,000	Member
	\$4,000	Family	\$6,000	Family
Hospital Admission Deductible	\$250 Per admission		No Charge	
Emergency Room Deductible	\$50 Per visit		\$50 Per visit	



Deductibles, Copayments & Out-of-Pocket Maximums are NOT eligible

For 2015, the following categories ARE eligible for reimbursement per 10.2.1 of the District-FA Agreement:

Check box for each type of reimbursement applied	Benefits	PERScare Member Pays			PERS Choice Member Pays			Eligible for Reimbursement (Based on PPO charges)
		PPO	Non-PPO	Comments	PPO	Non-PPO	Comments	
<input type="checkbox"/>	Chiropractic & Acupuncture	10%	40%	Max <del>20 visits</del> per calendar year for any combination of chiropractic/acupuncture	20%	40%	Max <del>15 visits</del> per calendar year for any combination of chiropractic/acupuncture	16-20 visits 90%
<input type="checkbox"/>	Home Health Care	10%	40%	Skilled care, NOT custodial care, up to <del>100 visits</del> per calendar year.	20%	40%	Skilled care, NOT custodial care, up to <del>45 visits</del> per calendar year.	46-100 visits 90%
<input type="checkbox"/>	Occupational Therapy	10%	10%	No Limit on Visits	20%	20%	Limited to a combined total of <del>24 visits</del> per calendar year for physical and occupational therapy.	25+ visits 90%
<input type="checkbox"/>	Physical Therapy	10%	40%	No Limit on Visits	20%	40%	Limited to a combined total of <del>24 visits</del> per calendar year for physical and occupational therapy.	25+ visits 90%
<input type="checkbox"/>	Skilled Nursing Care and Rehabilitation Care			Up to <del>100 days</del> per calendar year.			Up to <del>100 days</del> per calendar year.	
	Medically necessary skilled care, NOT custodial care, in a skilled nursing facility.	10%	40%	Days 1-10	20%	40%	Days 1-10	Days 101-180 80%
		20%	40%	Days 11-180	30%	40%	Days 11-100	



Benefits = Category



Eligible for Reimbursement

# Comparison Chart

## Retired Employees



Are you retired and Medicare Eligible?  
Use this chart



Benefits = Category



Check Plan Year



Eligible for Reimbursement

Santa Monica College  
Comparison of PERSCare and PERS Choice for SMCA -SMCCD Art. 10.2  
**Medicare Coverage**  
**2015 Plan Year**

For 2015, the following categories **ARE eligible for reimbursement** per 10.2.1 of the District-FA Agreement:

Check Box for each type of reimbursement	Benefit Category	Medicare PERSCare			Medicare PERS Choice			Eligible for Reimb.
		Member Pays	Comments	Covered by Plan	Member Pays	Comments	Covered by Plan	
<input type="checkbox"/>	Acupuncture	20%	20 visits per year	1-20 visits	100%	Not covered	0 visits	1-20 visits (80%)
<input type="checkbox"/>	Blood Replacement	20%	20% Copay for blood replacement for first 3 pints	Pints #1-3 (80%)	0%	Not covered (Member pays customary charges for pints #1-3 or arranges to have blood replaced)	0	Pints #1-3 (80%)
<input type="checkbox"/>	Hearing Aid Services	20%	Per member	\$2,000/24 months	20%	Per member	\$1,000/36 months	80% of PERSCare allowance minus PERS Choice allowance
<input type="checkbox"/>	Hospital (Inpatient)	0%	0-90 days plus reserve days *(lifetime max of 60 reserve days); No Charge	0-90 days*	0%	0-90 days plus reserve days *(lifetime max of 60 reserve days); No Charge	0-90 days*	0
<input type="checkbox"/>		20%	91+ days plus reserve days; 20% copay	91+ days*	100%	No coverage after 90 days plus reserve days	0	80% of expenses after day 90 (plus reserve days)
<input type="checkbox"/>	Hospital (Outpatient)	0%	No charge for Medicare-approved services	100%	0%	No charge for Medicare-approved services	100%	0
<input type="checkbox"/>		20%	20% copay for services beyond Medicare	80%	100%	No coverage for services beyond Medicare	0	80% of allowed PERSCare cost
<input type="checkbox"/>	Mental Health (Inpatient)	0%	No charge for Medicare-approved services	0-90 days*	0%	No charge for Medicare-approved services	100%	0
<input type="checkbox"/>		20%	20% copay for services beyond Medicare maximums	91+ days*	100%	No coverage for services beyond Medicare	0	80% of allowed PERSCare cost
<input type="checkbox"/>	Occupational Therapy/Speech Therapy	0%	No charge up to \$1,880 limit per year	\$0.00-\$1,880/yr	0%	No charge up to \$1,880 limit per year	\$0.00-\$1,880/yr	0
<input type="checkbox"/>		20%	Expenses exceeding limit/year (\$5,000 lifetime maximum for Speech Therapy)	\$1,881+/yr	100%	Expenses exceeding limit/year	\$1,881+/yr	80% of allowed PERSCare cost/yr (\$5,000 lifetime maximum for Speech Therapy)
<input type="checkbox"/>	Skilled Nursing Care	0%	1-100 days each benefit period (in a Medicare-approved facility)	1-100 days	0%	1-100 days each benefit period	1-100 days	0
<input type="checkbox"/>		20%	101-365 days	80%	100%	101+ days	101+ days	80% of allowed cost for 101-365 days

2015 Plan Year - MEDICARE COVERAGE Page 1 of 2 01/16/2015

# Supporting Documentation

## Collect Supporting Documents

For each claim you must submit the following:

- Explanation of Benefits (EOB) statement from insurance carrier. A sample EOB can be found at:

<https://www.blueshieldca.com/employer/documents/administrator-resources/help/sample-evidence-of-benefits-eob.pdf.pdf>

### **And always you must include:**

- Itemized statement that indicates the name of provider, patient name, cost, date of service, description of service (or code), and your amount paid to provider **Or** Proof of Payment Receipt – receipt of out-of-pocket expenses you paid to the provider.

**IMPORTANT**

*District may request additional information as needed*

# Organizing Supporting Documentation

## Organize by Category

- Benefit or category as found on the comparison chart

## Date of Service

- Date service was provided

## Example:

1. Receipts/EOBs for all Chiropractic visits organized by date of service;
2. Receipts/EOBs for physical therapy organized by date of service;
3. Etc.



# Submitting the Claim

- A claim must be submitted to the Office of Human Resources no later than one (1) calendar year following the *date of service* for an eligible faculty member and/or eligible dependents.
  - Note: If faculty member is incapacitated and unable to file a claim timely, a request for an extension may be granted up to two (2) calendar years following the date of service.*
- Submit Claim Form and Supporting documents to the Office of Human Resources:
  - By Mail:  
1900 Pico Blvd.  
Santa Monica, CA 90405
  - or
  - In-Person:  
2714 Pico Blvd, 2nd Floor  
Santa Monica, CA 90405



# The Decision

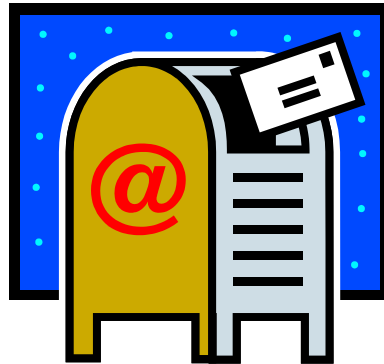
- **Claimant shall be notified via email of decision by Office of Human Resources.**



- **If there is no email address available, notification shall be sent by U.S. Mail to address on claim form.**

# Getting the Money

- ▶ Claimant will be notified when payment is issued by the District. Payment will be available for pick-up at the Office of Human Resources or mailed to the address on the claim form.





## Office of Human Resources Contact Us

### **Mailing address:**

1900 Pico Blvd  
Santa Monica, CA 90405

### **In person:**

2714 Pico Blvd, 2nd Floor  
Santa Monica, CA 90405

Questions: Please contact Lugina Rogers, HR Analyst, Leaves & Benefits at 310.434.4060 or [rogers\\_lugina@smc.edu](mailto:rogers_lugina@smc.edu)