



PERALTA BENEFITS – EVERYONE



**Enrollment
Deadline
9/11!**

Published by the PCCD Benefits Office

August 1, 2009

ADJUNCT BENEFITS OPEN ENROLLMENT ANNOUNCEMENT FOR THE FALL OF 2009

Peralta Benefits Office

333 East 8th Street

Oakland, CA 94606

www.peralta.pswbenefits.net

Email: benefits@peralta.edu

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**Available Downloads on
www.peralta.pswbenefits.net:**

1. Benefits Eligibility & Payment Highlights
2. Overview of Benefits
3. Medical Plan Highlights
4. Dental Plan Highlights
5. Benefits Matrix
6. Benefits for All Active Employees
7. Protected Health Information Disclosure
8. Eligibility Affidavit
9. Adjunct or Part-Time Faculty Benefit Checklist
10. Notification and Application of Pre-Existing Condition Exclusion
11. ARRA Frequently Asked Questions
12. Initial COBRA Notice



Check out your Benefits Information Center (BIC)

To learn more about your benefits, please visit your Benefits Information Center (BIC) website at:
www.peralta.pswbenefits.net.

Mandatory Re-enrollment for Continued or Initial Benefit Enrollment for Coverage September 1, 2009 - February 28, 2010

This notice is being sent to all adjuncts on record as of 07/27/09. However, receipt of this announcement is not an indication of any teaching assignment for Fall 2009.



- Current Enrollees ~ Coverage due to end on Monday, August 31, 2009. Re-enrollment required by Friday, September 11, 2009.
- New Enrollees ~ Enroll by Friday, September 11, 2009 or within 30 days of loss of other group coverage.

RE-ENROLLMENT IS REQUIRED TO ENSURE THAT ALL COMPLIANCE FORMS ARE ON RECORD WITH PCCD!

You may be eligible for participation in the District's medical, dental and flexible benefits plan enrollment. "The Benefit Eligibility & Payment Highlights" which outlines the eligibility criteria for the District group insurance plans for which you may be eligible. This memo is being sent to all active adjunct and part-time faculty on record as of July 29, 2009.

In order to initiate **OR** continue your enrollment, you must complete the following:

Employee Checklist

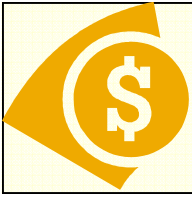
(check off as you go to confirm all necessary steps are completed)

- Determine** if you meet the enrollment criteria based upon your Fall 2009 instruction load ~ refer to "The Benefit Eligibility & Payment Highlights" and the Letter of Assignment from the Campus Office of Instruction.
- Complete and return the following forms by Friday, September 11, 2009.
 - Peralta Community College District Benefit Checklist (required by PFT Article 22 C-7)
 - Eligibility Affidavit and including **Letter of Assignment** issued by your campus
 - Adjunct Universal Benefit Enrollment Form
 - Application of Pre-Existing Condition Exclusion
 - Flexible Benefits Plan Enrollment Forms (including Pre-Tax Commuter Forms)

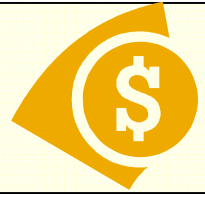
Note: No appointment is required to drop off forms. Drop-in office hours are Tuesdays from 2:00 pm to 4:00 pm. All forms stated above **MUST** be returned **TOGETHER** in order to affect an enrollment for the applicable plans (no exceptions). Enrollment forms for the tax deferred 403(b) plan participation and the legal plan are NOT subject to the September 11, 2009 deadline. Enrollment forms for these plans can be returned at any time.

If you have any questions about benefit plan features, you are encouraged to either:

- A) Visit the plan websites or contact vendors directly - www.peralta.pswbenefits.net
- B) Attend the Adjunct Open Enrollment Benefits Workshop on Tuesday, August 18, 2009 from 2:00–3:00pm in the District Office Board Room; or
- C) Attend a 15-minute forms processing session on Wednesday, September 2, 2009 at 10:00 am or 3:30 pm in the Benefits Office.



Benefit Eligibility & Payment Highlights
50% / 50% Medical Plan
100% Medical Plan



August 1, 2009

Plan	50% / 50%	100%
Governance	California Assembly Bill 420 California Education Code 87860—87868	
Re-Enrollment Required Each Academic Semester	Yes, no exceptions will be granted	
Plan Description	The 50% / 50% medical plan allows the District to contribute 50% of the group insurance premium for medical coverage (the coverage is extended to eligible dependents). The eligible faculty member is responsible for payment of the remaining 50% of the monthly premium through payroll deduction.	The District makes no contribution towards coverage. The faculty member receives the benefit of the PCCD group rate.
Eligibility Requirements	<ol style="list-style-type: none"> 1. Be a current employee as a temporary part time faculty member with the PCCD. 2. Be ineligible for other group coverage (paid for by another employer). 3. Have a teaching assignment which equals or exceeds 40% of an FTE. 	<ol style="list-style-type: none"> 1. Be a current employee as a temporary part time faculty member with the PCCD. 2. Be ineligible for other group coverage (paid for by another employer). 3. Have a teaching assignment which is less than 40% of an FTE.
Payment Schedule (3 months)	October, November and December 2009	
Coverage Duration (6 months)	September 2009 through February 2010	
Payment Method	Through payroll deduction. Personal check in cases where benefit election cost exceeds anticipated earnings. Other payment arrangements are considered on a case by case basis. Please contact the Benefits Office for additional information.	
Who Can Enroll?	Employee and eligible dependents as set forth by the benefit programs.	
Forms REQUIRED to Complete Enrollment and Comply with Regulations	<ol style="list-style-type: none"> 1) Peralta Community College District Benefit Checklist 2) Eligibility Affidavit 3) Adjunct Universal Enrollment Form 4) Application of Pre-Existing Condition Exclusion 5) Flexible Benefits Plan Enrollment Forms (& Pre-Tax Commuter Forms) ~ <i>optional</i> 6) Pre-Tax Commuter Forms ~ <i>optional</i> 	
Options of Medical Plans Available	<ul style="list-style-type: none"> •CoreSource PPO Plan (network through Anthem Blue Cross of California – Prudent Buyer PPO) •Kaiser 	
Dental Enrollment Possible?	Yes, however there is no District contribution. Coverage available through Delta Dental PPO or United HealthCare DMO Dental.	
Forms Deadline	Friday, September 11, 2009	










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Overview of Benefits Fall 2009

August 1, 2009

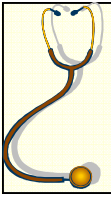
A benefit eligible employee is determined by the respective union's Collective Bargaining Agreement (CBA). For management and confidential employees, eligibility is generally extended to regular, full time employees who are scheduled to work at least 20 hours per week. Forms **MUST** be submitted within 30 days from date of hire or eligibility.

Vendor	Information on Vendors
	<p>Kaiser Medical Plan (Health Maintenance organization ~ HMO); www.kp.org Kaiser provides medical care through participating doctors at Kaiser facilities. The plan emphasizes preventive care and provides most services and supplies at little to no cost to you. The plan includes coverage for prescription drugs and optical services obtained at a Kaiser facility. The District plan allows for a \$10 copay for most services.</p>
	<p>CoreSource Medical Plan (Preferred Provider Organization ~ PPO); www.coresource.com CoreSource is the administer of the medical services received through the Anthem Blue Cross network (California residents) or PHCS network (non-California residents). To access Anthem Blue Cross providers, go to www.anthem.com/ca (if you are a California resident and traveling outside the State of California, access contracting providers from www.bluecares.com). To access PHCS providers, go to www.phcs.com. This network provides coverage throughout the United States. The PPO provides coverage for routine and major medical services received through network providers. Most office visits are available after a \$10 copay per visit.</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div data-bbox="284 989 446 1052" style="border: 1px solid black; padding: 2px;">  </div> <div data-bbox="495 989 1429 1052"> <p>Pharmacy benefits can be accessed through CVS / Caremark. www.caremark.com. Copays range from \$10 to \$15 per prescription for a 30 day supply.</p> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div data-bbox="284 1108 456 1171" style="border: 1px solid black; padding: 2px;">  </div> <div data-bbox="495 1108 1521 1203"> <p>Vision benefits can be accessed through Spectera; www.spectera.com. Participants can receive benefits through the Spectera network of providers and can receive out of network benefits within the plan guidelines. Office visit copays are \$10 for examinations.</p> </div> </div>
	<p>Delta Dental Plan (Preferred Provider Organization ~ PPO); www.deltadentalins.com Delta Dental pays 100% for most services, including preventive care, fillings, extractions, crowns, periodontics, and root canal work. Bridges and dentures are covered at 50%. The plan pays up to \$1,500 per person per calendar year. Orthodontia coverage is available for dependent children up to age 19. It is paid at 50% up to a calendar year maximum of \$1,000 per person.</p>
	<p>United HealthCare Dental Plan (Dental Maintenance Organization ~ DMO); www.myuhc.com United HealthCare Dental pays 100% for most services. In addition to routine cleanings, examinations and x-rays, this plan has an added feature of child AND adult orthodontia. Plan surcharge for orthodontia is \$2,250 when using a United HealthCare DMO dentist.</p>
	<p>Flexible Benefits Plan & Pre-Tax Commuting Reimbursement; www.pensiondynamics.com Medical and/or Dependent Care Expense (IRS Section 125): Eligible employees can set aside tax free dollars for out of pocket medical expenses or dependent day care expenses. First, set the money aside from each paycheck, then submit receipts to recover tax free dollars. Check with a tax professional to learn if this option is feasible to your personal situation. Pre-Tax Commuting Expense (IRS Section 132): If public transportation is used to get to and / or from work, this account can be used to reimburse specified expenses with pre-tax dollars.</p>

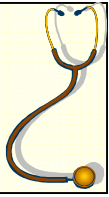


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**Medical Plan Highlights
CoreSource Medical PPO Plan
Kaiser Medical HMO Plan**



August 1, 2009

CORESOURCE PPO PLAN

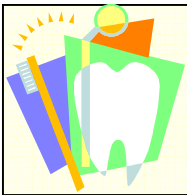
KAISER HMO PLAN

Plan	Network	Non-Network	Network
Calendar Year Deductible: <small>(deductibles cross accumulate)</small>	\$100 per person; 3 times individual deductible per family		None
Out of Pocket Maximum:	\$300 per person; \$900 per family	\$1,000 per person; \$3,000 per family	\$1,500 per person; \$3,000 per family
Lifetime Maximum Benefit:	\$5,000,000		Unlimited
Pre-Existing Condition Limitation:	6 months if enrolling when first eligible or 18 months if enrolling anytime thereafter. Limitation may be reduced by prior Creditable Coverage.		None
Network:	California residents access Anthem Blue Cross (www.anthem.com/ca); Non-California residents access PHCS (www.phcs.com)	Not applicable	Kaiser www.kp.org
Physician Office Visits:	\$10 copay (deductible waived)	80% of usual and customary fees, after calendar year deductible	\$10 copay
Diagnostic Testing, X-Rays and Laboratory:	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	100%
Inpatient Hospitalization:	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	100%
Pre-Certification of Inpatient Services:	Required. Penalty is 25% reduction of benefits. Does not apply to maternity or emergency visits.		Required. Penalty is 100% reduction of benefits. Does not apply to maternity or emergency visits.
Emergency Room Visits:	\$35 copay (deductible waived). Copay will be waived if admitted to the hospital.		\$35 copay. Copay will be waived if admitted to the hospital.
Out of Area Benefits:	If no contracting providers are within 30 miles of your residence, providers are considered in-network. Call CoreSource about water and/or mountain barriers.		Limited to life threatening emergency treatment only.
Vision Plan:	See Spectera brochure for schedule of Network and Non-Network vision benefits		Vision exam covered under medical plan. Materials benefit limited to \$175 allowance per 24 month period
Prescription Coverage:	Must use contracting pharmacy vendors ONLY! Retail is covered up to a 30 day supply at a \$10 copay for generic prescription or a \$15 copay for a brand name prescription. Mail order is covered up to a 90 day supply at a \$5 copay for either generic or brand name prescriptions. Retail Pharmacy Note ~ if a brand name drug is prescribed and there is no generic equivalent, then the member will ONLY pay the generic copay.		Retail and mail order is covered up to a 100 day supply at a \$10 copay for generic formulary or a \$15 copay for a brand name formulary.

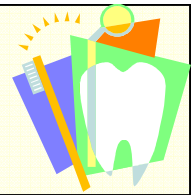


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Dental Plan Highlights Delta Dental PPO Dental Plan United HealthCare DMO Dental Plan



August 1, 2009

Plan	Delta Dental	United HealthCare
Network:	Delta Dental www.deltadentalins.com PPO Dental Plan	United HealthCare Dental www.myuhc.com DMO Dental Plan (HMO like plan)
Out of Network:	Okay, but is limited to Delta Dental's usual & customary fees	Not permitted. Must use United HealthCare Dental dentists ONLY.
Deductible:	None	None
Diagnostic & Preventative Services: (oral examinations, cleanings, x-rays)	Network: 100% of negotiated rate Non-Network: 100% of usual & customary fees; (balance billing may occur)	Network: 100% of United HealthCare fees Non-Network: No coverage available
Basic Services: (extractions, biopsies, fillings, root canals, sealants, gum treatment) ~ <i>both plans charge the patient if asked for resin or porcelain on molars, or if asked for a higher level metal than what is considered dentally appropriate.</i>	Network: 100% of negotiated rate Non-Network: 100% of usual & customary fees; (balance billing may occur)	Network: 100% of United HealthCare fees Non-Network: No coverage available
Crowns, Jackets, Other Cast Restorations ~ <i>both plans charge the patient if asked for resin or porcelain on molars, or if asked for a higher level metal than what is considered dentally appropriate.</i>	Network: 100% of negotiated rate Non-Network: 100% of usual & customary fees; (balance billing may occur)	Network: 100% of United HealthCare fees Non-Network: No coverage available
Prosthetic Services: (bridges, partial and full dentures)	Network: 50% of negotiated rate Non-Network: 50% of usual & customary fees; (balance billing may occur)	Network: 100% of United HealthCare fees Non-Network: No coverage available
Calendar Year Maximum (Per Person):	\$1,500	Unlimited
Orthodontia Services:	Dependent children only to age 19; Network: 50% of negotiated rate Non-Network: 50% of usual & customary fees Benefits limited to a separate \$1,000 per person per calendar year maximum	100% of United HealthCare fees not to exceed \$2,250 in patient copays. Benefits available to children and adults .



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Benefits Matrix—Fall 2009

August 1, 2009

Benefits Matrix	Benefit Classification as Defined by Benefit Program Assignment			
	PRB—Full Time 39, 1021, Management, Confidential	PFF—Contract Faculty	PAB—Adjunct Hourly	TCB—Temporary Classified Benefits
Designations to appear on paychecks	PRB	PFF	PAB	TCB
Workers Compensation	●	●	●	●
Medical *(refer to Benefits Eligibility & Payment Highlights for explanation on costs)	●	●	● *	
Dental	●	●	● (District does not make contributions)	
Employee Assistance Program	●	●		
Flexible Benefits 125, 132	●	●	●	●
Pre-Tax Parking	●	●	●	●
Pre-Tax Transportation	●	●	●	●
Tax Deferred annuities—403(b)	●	●	●	●
Tax Deferred Annuities—457(b)	●	●	●	●
Defined Benefit Plans—401(a) STRS		●	●	
Defined Benefit Plans—401(a) PERS	●			
Cash Balance			●	
Apple				●
Term Life	●	●		
Long Term Disability	●	●		
Union Dues / Fees	●	●	●	●

Benefits Premium Formula	Formula: (50% / 50%)		
<i>Note, If you are not eligible for District contribution, you may be eligible to pay the full amount.</i>	1) Take the monthly rate (ex. 503.37) 2) Multiply the number of months of coverage (6 months ~ Sept., Oct., Nov., Dec., Jan. and Feb.) (ex. 503.37 * 6 = \$3020.22) 3) Divide by the number of pay periods (3 months ~ Oct., Nov. and Dec.) (ex. 3020.22 / 3 = 1006.74) 4) Divide by 2 if eligible for the 50% / 50% plan. (ex. 1006.74 / 2 = 503.37)		
Group Insurance Plans (Monthly Rate)	Single	Two Party	Three or More
Kaiser <i>(rate in effect through 08/31/10)</i>	\$503.37	\$1,006.74	\$1,424.53
CoreSource <i>(rate in effect through 08/31/10)</i>	\$535.22	\$1,195.84	\$1,796.53
Delta Dental <i>(rate in effect through 08/31/10)</i>	\$65.04	\$110.57	\$169.11
United HealthCare Dental <i>(rate in effect through 08/31/10)</i>	\$25.03	\$40.06	\$61.05

KAISER REIMBURSEMENT PROGRAM FOR MAIL ORDER PRESCRIPTONS

Eligibility:	Active Members of Unions, PFT, 1021, 39, confidential & management employees
Frequency of Reimbursement:	Semi Annually (July and January)
Documentation Guidelines:	Complete Reimbursement Form and Supply Receipts (download form at www.peralta.pswbenefits.net under the Medical / Kaiser HMO link)

Benefits for All Active Employees

August 1, 2009

WORKERS' COMPENSATION INSURANCE

All District employees are automatically covered by workers' compensation benefits. If an employee is injured while on the job and if the claim is accepted by the District's workers' compensation claims administrator, the benefits include coverage for medical and rehabilitation expenses associated with the injury. The District provides full salary for the first 60 days, under the Peralta Industrial Leave policy. Our claims are administered through Southern California Risk Management Associates, Inc. Medical services are rendered through the *Medical Provider Network* with many providers and specialists in the area.

Refer to plan booklets for other information on the benefits of retirement plan participation. In addition to retirement income, each plan may offer other pre-retirement planning opportunities (long-term care, home loan programs and more).

RETIREMENT PLANS (PERS, APPLE, STRS, Cash Balance)

Depending on your position and your appointment, you participate in either the Public Employees' Retirement System (PERS), the State Teachers' Retirement System (STRS) or the APPLE Plan. Inquire with Human Resources or each respective retirement plan system regarding plan membership

The employee contributes 7% of salary and this contribution is tax-deferred. The District currently contributes 9.116% of salary to the members' PERS retirement fund.

Employees who are part time, seasonal or temporary may be eligible for the Accumulation Program for Part-time and Limited Service Employees (APPLE). Your mandatory contribution is 3.75% of eligible salary; the District contributes 3.75% of your eligible salary to this plan.

The contribution rate is based on the academic term (10, 11 or 12 month) assigned to the faculty member and is tax deferred. The District currently contributes 8.25% of the member's annual salary to the STRS fund (see the Monthly Contribution Table which follows).

Part time educators may be eligible for participation in the defined benefit plan Cash Balance Benefit Program. Both the employee and employer contribute 4% of salary to this retirement fund.

VOLUNTARY 403(B) & 457 PLANS

Tax Shelter Programs & Personal Financial Planning

Under Section 403(b) of the Internal Revenue Code and Section 17512 of the California Revenue and Taxation Code, Peralta employees may participate in the District's tax shelter programs now administered through Great American Plan Administrators. We also offer tax-deferred saving opportunities through the 457 Plan which is also serviced by Great American Plan Administrators. Maximize your tax savings and minimize your tax liability through these plans! Visit the PCCD website (www.peralta.edu) to download forms and check investment options.

LABOR UNIONS

Unions/Associations

These unions and associations represent the employees in contract negotiations with the District concerning issues such as salary, benefits, hiring practices, working conditions, etc.

Monthly dues:

- Peralta Federation of Teachers (www.pft1603.org)
- Regular/Contract/Accelerated Faculty: 0.01493 of any gross salary (plus approved AFT/CFT pass-throughs)
- Hourly Part-time Faculty:
 - \$16.60 for each month of employment for three (3) equated hours or less (plus approved AFT/CFT pass-throughs)
 - \$28.59 for more than three (3) equated hours (plus approved AFT/CFT pass-throughs)
- United Public Employees, Local 1021 of the Service Employee International Union (www.seiu1021.org)
 - Monthly dues are 1.80% of base salary; 1.70% for temporary employees.
- International Union of Operating Engineers, Local 39 of the AFL-CIO (www.local39.org)
 - Monthly dues are twice the hourly rate plus \$4.25.

Protected Health Information

Please review this document carefully. The privacy of your health information is important to us!

August 1, 2009

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duty, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice has been in effect since April 13, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION & EMPLOYEE RIGHTS

Access: You have the right to look at or get copies of your health information, if any exists in any offices, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00, for each page \$15.00, per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions & Complaints: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. Contact: Privacy Officer: Jennifer Seibert (510) 587-7868, Address: 333 East 8th Street, Oakland, CA 94606.

Notification of Pre-Existing Condition Limitation ARRA Frequently Asked Questions

Notification of Pre-Existing Condition Limitation

A group health plan makes coverage effective on the first of the month following your initial date of hire and on each **open enrollment period** following. Open enrollment generally occurs in February and August of each calendar for adjunct employees and in October of each year for all other employees.

The plan imposes a **6 month** maximum pre-existing condition exclusion (18 months for late enrollees) and uses a **6 month** look back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment recommended or received within a **6 month period**. Generally, this **6 month period** ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 6 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the **6 months** (18 months if you are late enrollee) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to :

Jennifer Seibert
District Benefits Coordinator
Peralta Community College District
333 East 8th Street,
Oakland, CA 94606
Phone number: 510 587.7868
Email: jseibert@peralta.edu

ARRA Frequently Asked Questions

On February 17, 2009, President Obama signed into law a stimulus bill (known as the American Recovery and Reinvestment Act (ARRA) of 2009). ARRA has many sweeping changes to the COBRA Consolidated Omnibus Reconciliation Act Legislation. Below is a summary of the legislation as it applies to you and your eligible IRS dependents.

- The federal government will pay 65% of premiums for people eligible for COBRA due to an involuntary job loss between September 1, 2008 through December 31, 2009.
- Subsidy-eligible employees and eligible family members must pay 35% of the COBRA premium to qualify.
- The premium subsidy will be available immediately and will **last for up to nine months** (subsidy will end on the earlier of the date the individual becomes ELIGIBLE for coverage under another health plan or Medicare.)
- A qualified beneficiary who requests treatment under a plan as a subsidy eligible individual and is denied that benefit will have a right to an expedited appeal directly to the Department of Labor and Treasury. By law, these departments will make a determination of eligibility within 15 business days.

While this legislation is new and many scenarios are possible, you are encouraged to visit the Department of Labor website at www.dol.gov for the most recent updates. DOL Notice 2009-27 contains comprehensive Q & A's as addressed under the legislation. Please visit the PCCD Benefits website at www.peralta.pswbenefits.net for more information.

**Peralta Community College
Eligibility Affidavit
50% / 50% and 100% Plan
Fall 2009**

RETURN THIS FORM TO THE BENEFITS OFFICE NO LATER THAN FRIDAY, SEPTEMBER 11, 2009. INCOMPLETE OR FORMS RECEIVED AFTER THIS DATE WILL NOT BE PROCESSED AND WILL BE RETURNED TO YOU.

Section A: Personal Information

Employee's Name (Last, First, Middle Initial) - please print	Social Security Number	Date of Birth
Street Address - please print	City	State
Telephone Number (home)	Telephone Number (work)	Email Address

Check here if the above reflects any new / updated contact information.

Section B: Affidavit of Eligibility

Please answer Yes or No to questions 1, 2, and 3. Initial next to your response.

1. Are you currently employed by PCCD as any hourly faculty member? Yes No _____ (your initials here)
2. Do you have a fall assignment of 40% or greater? Yes No _____ (your initials here)
(refer to the Instructor Assignment Roster—**attach the Instructor Assignment roster to this form**)
3. Do you have other access to group medical insurance where all or part of the premium is paid through some source other than personal funds or a Community College District? Yes No _____ (your initials here)

Section C: Benefit Options—Circle your Choices and Attach an Adjunct Universal Enrollment Form

Coverage 50% / 50% Plan	Your 50% / 50% Monthly Share: 6 months of coverage paid in 3 in- stallments Kaiser Monthly Rate/Payroll Rate	Your 50% / 50% Monthly Share: 6 months of coverage paid in 3 installments CoreSource Monthly Rate/Payroll Rate	Coverage 100% Plan	Your 100% Monthly Share: 6 months of cover- age paid in 3 installments Kaiser Monthly Rate/Payroll Rate	Your 100% Monthly Share: 6 months of cover- age paid in 3 installments CoreSource Monthly Rate/Payroll Rate
Single	\$251.68/mo; 503.36/pr	\$267.61/mo; 535.22/pr	Single	503.37/mo; 1006.74/pr	535.22/mo; 1070.44/pr
Two Party	\$503.37/mo; 1006.74/pr	\$597.92/mo; 1195.84/pr	Two Party	1006.74/mo; 2013.48/pr	1195.84/mo; 2391.68/pr
Three Party	\$712.26/mo; 1424.52/pr	\$898.26/mo; 1796.52/pr	Three Party	1424.53/mo; 2849.06/pr	1796.53/mo; 3593.06/pr

Coverage Employee makes 3 installments for 6 months of coverage	Delta Dental PPO Dental Plan You pay full monthly premium	United HealthCare DMO Dental Plan You pay full monthly premium
Single	\$65.04	\$25.03
Two Party	\$110.57	\$40.06
Three Party	\$169.11	\$61.05

I understand that if I waive coverage or do not enroll in coverage, I can enroll at a later date if there is a QUALIFYING EVENT as permitted and defined by HIPAA governances.

Section D: Payroll Deduction Authorization

50% / 50% Plan: I hereby authorize Peralta Community College District Payroll Department to deduct the **above-referenced CIRCLED** amounts from my monthly paycheck to pay for 50% of the medical premium cost and 100% of the dental premiums for the amount of coverage I have selected. Deductions will occur for the 3 pay periods Oct., Nov. and Dec. 2009.

_____ (please sign and date)

OR

100% Plan: I hereby authorize Peralta Community College District Payroll Department to deduct the **above-referenced CIRCLED** amounts from my monthly paycheck to pay for 100% of the medical and or dental premium cost for the amount of coverage I have selected. Deductions will occur for the 3 pay periods Oct., Nov. and Dec. 2009. I do not qualify for the District contribution and agree to pay 100% of the above-referenced circled premium. _____ (please sign and date)

Section E: Complete and Attach Required Forms:

Letter of Assignment from Department, Adjunct Faculty Benefit Checklist & Universal Enrollment Form Checklist are attached to this Affidavit.
_____ (initial here)

Peralta Community College District Benefits Enrollment Checklist
(6 forms are required plus documentation of full time equivalent (FTE) for academic term)
(Shaded portion of the form does not apply to Adjunct Employees)

Rev. August 1, 2009

Information Received	Website Links	You may download forms from our Benefits Information Center website (link provided left) or contact the Benefits Office for hard copies.
1. Benefit Newsletter	www.peralta.pswbenefits.net	
2. Initial / General COBRA	www.peralta.pswbenefits.net	
3. Kaiser Packet	www.peralta.pswbenefits.net	
4. Kaiser Disclosure & Plan Highlights		
5. CoreSource Summary Plan Description	www.peralta.pswbenefits.net	
6. CoreSource Pre-Existing Application & Notice	www.peralta.pswbenefits.net	
7. CoreSource Caremark—List of Pharmacies	www.peralta.pswbenefits.net	
8. CoreSource Caremark—Mail Order Prescriptions		
9. Spectera Vision Care Benefits	www.peralta.pswbenefits.net	
10. Delta Dental Overview	www.peralta.pswbenefits.net	
11. Delta Dental Evidence of Coverage		
12. UnitedHealthCare Dental Lists / Costs		
13. Flexible Benefits Plan Medical & Dependent Care Program	www.peralta.pswbenefits.net	
14. Section 132 Pre-Tax Parking & Commuter	www.peralta.pswbenefits.net	
15. Tax-Deferred 403(b) & 457(b) Highlights & Comparison	www.peralta.edu	
16. Employee Assistance Program Overview	www.peralta.pswbenefits.net	
17. Voluntary Legal Plan Overview & Service List	www.peralta.pswbenefits.net	
18. Citibank-at-Work Program Flyer	www.peralta.pswbenefits.net	
19. Life Insurance Overview	www.peralta.pswbenefits.net	
20. Life Insurance Certificate of Coverage	www.peralta.pswbenefits.net	
21. Long Term Disability Overview	www.peralta.pswbenefits.net	
22. Long Term Disability Certificate of Coverage	www.peralta.pswbenefits.net	
23. Voluntary Term Life CIGNA Overview	www.peralta.pswbenefits.net	
The following forms MUST be returned within 31 days from date of hire or state date (whichever occurs later) Received by Benefits Office or N/A		
24. Universal Enrollment Form	www.peralta.pswbenefits.net	
25. Pre-Existing Exclusion Application		
26. Flexible Benefits Plan Enrollment Medical & Dental	www.peralta.pswbenefits.net	
27. CIGNA Voluntary Life Insurance Application	www.peralta.pswbenefits.net	
28. Cash in Lieu of Benefits Form	www.peralta.pswbenefits.net	
The following forms may be returned at any time:		
29. Pre-Tax Commuting Enrollment	www.peralta.pswbenefits.net	
30. Pre-Paid Legal Enrollment Form	www.peralta.pswbenefits.net	
31. Salary Reduction Agreement Form 403(b) & 457(b)	www.peralta.edu	

WAIVER AND ACKNOWLEDGEMENT: I have read & understand my options. If I enroll in a group insurance plan, I agree to notify the District within 30 days of a qualifying event. If I do not enroll now, I understand that I may enroll at a later date subject to open enrollment provisions. If payroll deductions are required for medical or dental, I agree that they will be pre-tax and I will advise PCCD if I prefer after tax deductions.

Signature: _____

Date: _____

Application of Pre-Existing Condition Exclusion

Submit this form with the Adjunct Universal Enrollment Form

August 1, 2009

If enrolling on the Kaiser plan, complete sections A & C.
If enrolling on the CoreSource plan, complete sections A through C.

SECTION A

Employee and/or Dependent Name(s):

Hire date:

First eligible to enroll date:

Definition of Pre-Existing Condition: medical advice, diagnosis, care, or treatment recommended or received within a 6 month period. Generally, this 6 month period ends on the day before the waiting period begins.

ADJUCTS ONLY: check here if enrollment is continuing from prior semester.

SECTION B

As required under Federal law, we advised you and your eligible dependent(s) of contractual pre-existing condition exclusions under the self-funded plan (currently administered by CoreSource) offered by Peralta Community College District. Submit any evidence of prior coverage along with your Universal Enrollment form and within 30 days of coverage effective date. PCCD will only accept the Certificate of Creditable Coverage as issued from your prior insurer. Ask your former group insurance administrator for this Certificate. Your prior insurer is required to provide it upon request. PCCD will assist you acquiring this document from the prior carrier or employer should you so request, in writing.

Your pre-existing condition exclusion period may be reduced by prior creditable coverage as defined by the law. As of this date, you have:

- Submitted the Certificate of creditable coverage and have satisfied the pre-existing conditions limitation period in full. Evidence is attached.
Not submitted any evidence of prior creditable coverage. Therefore, the full limitation period applies.
Submitted certification of prior creditable coverage. This totals days/months for all persons to whom this notice applies. This time can be used to offset the pre-existing condition exclusion period of our plan. Therefore, you will only be subject to days/months of limitation for pre-existing conditions from your date of hire (this includes any applicable waiting period).

You have the legal right to submit further certification of prior waiting periods and creditable coverage as it becomes available. If you disagree with the findings of this notice, please submit your disagreement, in writing to: Jennifer Seibert, District Benefits Coordinator, Peralta Community College District, 333 East 8th Street., Oakland, CA 94606, Phone number: 510 587-7868, Email: jseibert@peralta.edu

Note: Should your claims be denied in whole or in part by the insurance company based on the application of a pre-existing conditions limitation in excess of that stated above, contact Benefits Office for assistance in resubmitting your claim.

SECTION C

I understand that I am enrolling in the self-funded plan and I have been asked to provide a certificate of creditable coverage; or I understand that I am enrolling in the Kaiser plan and there is no pre-existing condition exclusion limitation for new or continuing enrollments on the plan.

Employee Signature

Date

Employer Signature

Date

UNIVERSAL BENEFIT RE-ENROLLMENT FORM

ALL BENEFIT CHANGES MADE ON THIS ENROLLMENT FORM
WILL BE EFFECTIVE 09/01/09 – 02/28/10

PERALTA COMMUNITY
COLLEGE DISTRICT



*****ADJUNCT EMPLOYEES ONLY*****

COMPLETE SECTIONS 1-8 AND RETURN TO THE BENEFITS OFFICE

NO LATER THAN FRIDAY, SEPTEMBER 11, 2009

1. EMPLOYEE INFORMATION (Please Print)

Employee Name (last name, first name, middle initial)		SHADED AREA FOR OFFICE USE ONLY:						
Employee Address (street, city, state, zip code)						EFFECTIVE DATE:	September 1, 2009	
						MEDICAL GROUP/DIVISION #:	Kaiser: 65-51 or Coresource: Grp 2 Div 49	
						DENTAL GROUP/DIVISION #:	Delta: 938-1501 or UHC DMO: 04N6331	
						FORM REVIEWED & APPROVED BY:		
		DATE REVIEWED & APPROVED:						
Home Phone:	Alternate Phone:	Email Address:						
Work Location	Occupation Adjunct Prof	Social Security Number:	Date of Birth	Date of Hire:	Date of Retirement:			
Hours/Week	Gender	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow <input type="checkbox"/> Domestic Partner						

2. INDIVIDUALS COVERED

(A)dd (C)hange (D)rop	Name	Social Security Number	Date of Birth	Sex	Relationship Spouse Domestic partner Child-natural Child-foster Child-adopted	Totally Disabled?	IRS Dependent?	Medical/ Vision	Dental
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

3. BENEFIT PLANS

•MEDICAL/ VISION	Choose one:	<input type="checkbox"/> Kaiser Permanente HMO <input type="checkbox"/> Coresource PPO/Vision* <small>*Pre-existing condition limitations apply; 6 months for new hires; 18 months for late entrants</small> Division Name: Adjunct Group #:2 / Division #:49 <i>Please refer to the Eligibility Affidavit for a breakdown of premiums and your costs.</i>	Choose one:	(1) Employee only <input type="checkbox"/> Kaiser <input type="checkbox"/> Coresource (2) Employee + 1 dependent <input type="checkbox"/> Kaiser <input type="checkbox"/> Coresource (3) Employee + family <input type="checkbox"/> Kaiser <input type="checkbox"/> Coresource
•DENTAL	Choose one:	<input type="checkbox"/> Delta PPO Dental <input type="checkbox"/> UHC DMO Dental (<i>MUST</i> designate DMO Provider) Name of UHC DMO Provider: _____ DMO Provider #: _____ <small>(You may obtain the DMO provider # by calling Customer Service at 800-999-3367)</small> <i>Please refer to the Eligibility Affidavit for a breakdown of premiums and your costs.</i>	Choose one:	(1) Employee only <input type="checkbox"/> Delta Dental <input type="checkbox"/> UHC Dental (2) Employee + 1 dependent <input type="checkbox"/> Delta Dental <input type="checkbox"/> UHC Dental (3) Employee + family <input type="checkbox"/> Delta Dental <input type="checkbox"/> UHC Dental

Unless you check below, your premium WILL be deducted on a pre-tax basis from your PCCD pay:

I do **NOT** wish to have my premiums deducted on a pre-tax basis.

Signature _____ Date _____

Print First Name _____ Print Last Name _____

****Please attach Letter of Assignment issued by your Campus' Office of Instruction****

4. OTHER HEALTH INSURANCE

1. Is anyone listed eligible for Medicare? Yes No If Yes, Medicare # _____
If yes, who? _____
2. Is anyone listed eligible for Medicaid or CHIP? Yes No ID# _____
If yes, who? _____
3. Are you or have you and/or any of your eligible family members been covered by other medical coverage within the last six months? Yes No If yes, complete the section below. Please list all current or prior medical coverage. Failure to provide complete information may result in significant delay of claims processing (attach additional sheets if necessary).

COVERED PERSON'S NAME (Last, First M.I.)	Policy Holder's Name	Insurance Company Name	Type of Coverage	Policy #	Termination Date (if applicable)
			<input type="checkbox"/> Health <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Health <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Health <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Health <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Health <input type="checkbox"/> Other: _____		

5. KAISER ENROLLEES MUST READ AND SIGN:

Kaiser Foundation Health Plan Arbitration Agreement: Check if NOT enrolling in Kaiser

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

EMPLOYEE SIGNATURE

DATE

6. CORESOURCE ENROLLEES MUST READ AND SIGN:

Check if NOT enrolling in Coresource

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements.

ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions:

I understand that any and all disputes between myself (and/or any enrolled family member) and CoreSource for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and CoreSource are giving up the right to have any dispute decided in a court of law before a jury. CoreSource and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate.

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

EMPLOYEE SIGNATURE

DATE

7. COMPLETE THE APPLICABLE SECTION BELOW TO DETERMINE YOUR TOTAL PER PAY PERIOD DEDUCTION:

50/50 Plan – see below for premium rates 09/1/09 – 02/28/10:

Medical Premium \$ _____ ÷ 2 = \$ _____ X 6 = \$ _____ ÷ 3 = \$ _____ (your share)
 + Dental Premium \$ _____ X 6 = \$ _____ ÷ 3 = \$ _____ (your share)
TOTAL MEDICAL AND DENTAL PREMIUM PER PAY PERIOD: \$ _____ (your share)

100% Plan– see below for premium rates 09/1/09 – 02/28/10:

Medical Premium \$ _____ X 6 = \$ _____ ÷ 3 = \$ _____ (your share)
 + Dental Premium \$ _____ X 6 = \$ _____ ÷ 3 = \$ _____ (your share)
TOTAL MEDICAL AND DENTAL PREMIUM PER PAY PERIOD: \$ _____ (your share)

PREMIUM RATES

Current 09/01/09 Monthly
Premium Rates

Medical PPO (Coresource)

Single: \$ 535.22
 Two Party: \$1,195.84
 Three Party: \$1,796.53

Medical HMO (Kaiser)

Single: \$ 503.37
 Two Party: \$1,006.74
 Three Party: \$1,424.53

Dental PPO (Delta)

Single: \$ 65.04
 Two Party: \$ 110.57
 Three Party: \$ 169.11

Dental DMO (United HealthCare)

Single: \$ 25.03
 Two Party: \$ 40.06
 Three Party: \$ 61.05

8. TERMS AND AGREEMENT (ALL EMPLOYEES MUST SIGN AND DATE BELOW):

I agree to notify the District in writing within 30 days of the following:

1. my address change
2. change to my marital status resulting in adding or deleting a spouse or domestic partner
3. change to my eligible dependents status adding a newborn

I also acknowledge that in accordance with Peralta Community College District Board Policy, civil action may be brought against employees who make false statements or fail to notify the District of change in dependent status.

I agree to pay premium directly from my Peralta Community College District pay. If there are insufficient earnings, I will pay for benefits by personal check within the first 10 days of the coverage month or face cancellation of coverage for non-payment of premium.

EMPLOYEE SIGNATURE

DATE