Date: August 10, 2006

To: **Temporary, Part-time Faculty Members**
Peralta Federation of Teachers (PFT) members

From: Jennifer Seibert, (510) 587-7838-jseibert@peralta.edu
Peralta Community College
District Benefits Coordinator

Re: Current Coverage due to end on August 31, 2006
Re-enrollment required by Friday, September 22, 2006

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

Our records indicate that you may be eligible for participation in the District's medical, dental, flexible benefit plans enrollment based on your past part-time teaching load with the District. Enclosed with this memo is a ***Frequently Asked Questions*** which outlines the eligibility criteria for the District Group Insurance Plans for which you may be eligible. This memo is being sent to all adjunct and part-time faculty.

In order to initiate your enrollment:

A. **Determine** if you meet the enrollment criteria based on your past teaching load from the most recent 4 semesters. Refer to the enclosed *FAQ* for guidance.

B. If you satisfy the eligibility requirement, then **complete and return the following forms by Friday, September 22, 2006**; these forms are included/or attached to this memo:

1. Eligibility Affidavit
2. Peralta Community College District Benefit Checklist (required by PFT article C-7)
3. Initial COBRA Notice
4. *Universal* medical and dental plan enrollment form for you and your eligible dependents
5. Flexible Benefits Plan enrollment forms

Enrollment forms for the tax deferred 403(b) plan participation and the legal plan are not subject to the September 22, 2006 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

- visit the plan websites as noted on the enclosed *Benefits Overview-Reference Information or*
- attend a 15-minute forms processing session on Thursday, September 14, 2006 at 10:00 am or 3:30 pm District Benefits Office. These sessions are optional.

RE-ENROLLMENT IS REQUIRED TO ENSURE THAT ALL COMPLIANCE FORMS ARE ON RECORD WITH PCCD. Your enrollment is complete if you return the following completed forms by the deadline of Friday, September 22, 2006. Eligibility Affidavit
Peralta Community College District Benefit Enrollment Form
Adjunct or Part Time Faculty Benefit Enrollment Checklist

Link to vendor enrollment forms and other useful benefits information:
Peralta Colleges Benefits Information Center

FREQUENTLY ASKED QUESTIONS
50/50 MEDICAL PLAN
100% MEDICAL PLAN
Fall 2006

Plan	50/50	100%
Governances	California Assembly Bill 420	Article 22 of the PFT Contract
Re-enrollment Required each academic semester	YES	
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, the faculty member receives the benefit of a group rate.
Employment Status	Current member of PFT	Current member of PFT
Where can I obtain enrolment forms?	From website: www.peralta.pswbenefits.net From Benefits Office: 333 East 8th Street Oakland, CA 94606 Call 510 466-7353 From PFT Offices: 500 East 8th Street Oakland, CA 94606 Call 510 769-8820	
Eligibility Requirements Must meet all	You must: 1. Have maintained a .40 teaching load/ FTE (full-time equivalent) for the immediately preceding 3 consecutive semesters, excluding summer session 2. Be a current employment as a temporary part-time faculty member with the Peralta Community College District 3. Be ineligible for other coverage paid for by another employer.	You must have: Completed teaching four consecutive semesters in the immediately preceding four years-*semesters which are partially completed are excluded from the eligibility calculation.*
Payment Duration?	October - December	Month-to-month
Coverage Duration?	September 2006 – February 28, 2007 (6 months)	Month-to-month
Payment Method	Through payroll deduction	
Who can enroll?	Employee and eligible dependents	
Forms REQUIRED to complete enrollment and comply with regulations	1. *Peralta Community College District Benefit Enrollment Form for Kaiser, CoreSource, Delta, Pacific Union Dental* 2. *Eligibility Affidavit* 3. *Adjunct Benefits Checklist*	
Options of medical plans available	CoreSource Kaiser	
Forms Deadline	September 22, 2006	
Dental Enrollment Possible?	Yes, however, there is no District contribution Choose between Delta Dental and Pacific Union	

In the event of a break-in-service, employees will not lose their eligibility for benefits after return from break in service provided that:

- **They maintained their benefits pursuant to COBRA for the duration of their absence and**
- **They were absent for no more than 18 months; and**
- **One of the following situations applies**
  - **They have an approved leave in a category available to part-time faculty contained in the PFT Agreement; or**
  - **Cancellation of classes due to low enrollment, budgetary reasons, program needs or reassignment of the class to a contract regular faculty instructor.**

Peralta Community College District
Enrollment Affidavit
50/50% and 100% Plan
Fall 2006

RETURN THIS FORM TO THE BENEFITS OFFICE NO LATER THAN Friday, September 22, 2006
Incomplete or forms received or late forms will be returned to you.

A. PERSONAL INFORMATION

_____
Employee's Name (Print) Social Security Number Date of Birth

_____
Street Address City State Zip Code

_____
Telephone Number (Home) Telephone Number (Work) E-mail Address
( ) check here if address is new

B. ELIGIBILITY AFFIDAVIT
Please answer Yes or No to questions 1, 2, and 3. Fill in the blanks for Question 4, as applicable.

1. I am currently employed by PCCD as an hourly faculty member: _____

2. I have been employed by PCCD as an hourly faculty member for the past three (3) semesters with an assignment of .40 or greater: _____

3. I have/do not have other access to medical insurance where all or part of the premium is paid through some source other than personal funds or a community college District.

4. Fill in the blanks below.
My cumulative assignment load for the Fall 2006 is _____ and: If you are unsure, ask your Dean's Office for assistance and for validation of your course load – Course load:_____ Dean/Department signature _____ ph_____
My course load / FTE history is:

PCCD College course load history (ie SP 05, F04, S04, F03)	Class Assignment	Assignment Load/FTE 3 or 4 most recent consecutive semesters .
1. SPRING '06		
2.		
3.		

C. Benefit Options-circle your choices and attach enrollment form- To calculate your premium take the monthly rate X 6 (months of coverage) / 3 (pay periods)

COVERAGE	KAISER MONTHLY PREMIUM*	YOUR SHARE (50/50 PLAN ONLY)	CORESOURCE MONTHLY PREMIUM*	YOUR SHARE (50/50 PLAN ONLY)
Single	389.44	**194.72**	500.33	**250.16**
Two Party	778.88	**389.44**	1117.88	**558.94**
Family	1102.11	**551.05**	1679.42	**839.71**

COVERAGE	DENTAL YOU PAY FULL MONTHLY PREMIUM*	PACIFIC UNION DENTAL YOU MAY FULL MONTHLY PREMIUM*
Single	59.01	23.26
Two Party	100.31	37.22
Family	153.42	56.99

I understand that if I waive or do not enroll, I can enroll at a later date if there is a *qualifying event* as permitted and defined by ERISA governances._____

D. **Payroll Deduction Authorization:**
I hereby authorize the Peralta Community College District Payroll Department to deduct *$_____ from my monthly paycheck to pay for 50% of the premium cost for the amount of coverage I have selected. Deductions will occur for the 3 pay periods October, November, and December 2006.

E. **Complete and Attach Required Forms:**
___Adjunct or Part-Time Faculty Benefit Checklist _____Enrollment Form

Adjunct or Part-Time Faculty Benefit Checklist
Fall 2006

This form must accompany the Universal Benefit Re-Enrollment form

The following forms must be returned by Friday, September 22, 2006 or within 31 days of hire date, start date or qualifying event, whichever occurs later.

Informational literature and forms can also be downloaded from website www.peralta.pswbenefits.net

	To be checked by employee	Received by Benefits Office or N/A
1. Eligibility Affidavit		
2. Initial COBRA Notice		
3. Universal Medical & Dental Enrollment / Change / Waiver Form ***(if you are not enrolling for coverage, you still must complete this form, indicate "waive" where directed)***		
4. Flexible Benefits Plan Enrollment		
5. Pre-tax Commuting Enrollment		
The following forms can be returned at any time		
1. Pre-Paid Legal Enrollment Form		
2. Salary Reduction Agreement Form for 403(B) Plan		

Waiver and Acknowledgement

I have read and 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. I also understand that my premiums are pre-tax and I will notify the District if I prefer after-tax deductions.

Signature: _____ Date: _____

*A qualifying event occurs when there is a loss of coverage under another group plan. The employee is responsible for notifying the Peralta Community College District Benefits Office within 31 days of the loss in order to enroll in a PCCD insurance plan.

UNIVERSAL BENEFIT RE-ENROLLMENT FORM

ALL BENEFIT CHANGES MADE ON THIS ENROLLMENT FORM WILL BE EFFECTIVE 09/01/06-2/28/07

PERALTA COMMUNITY COLLEGE DISTRICT

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

COMPLETE SECTIONS 1-6 AND RETURN TO THE BENEFITS OFFICE NO LATER THAN 09/22/06

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:		
			MEDICAL GROUP/DIVISION #:		
			DENTAL GROUP/DIVISION #:		
			FORM REVIEWED & APPROVED BY:		
			DATE REVIEWED & APPROVED:		
Home Phone:		Alternate Phone:	Email Address:		
Work Location	Occupation	Social Security Number:	Date of Birth	Date of Hire:	Date of Retirement:
Hours/Week	Annual Salary $	Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widow ☐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
						☐Yes ☐No	☐Yes ☐No		
						☐Yes ☐No	☐Yes ☐No		
						☐Yes ☐No	☐Yes ☐No		
						☐Yes ☐No	☐Yes ☐No		
						☐Yes ☐No	☐Yes ☐No		

3. BENEFIT PLANS

•MEDICAL/ VISION	*Choose one*:	☐ Kaiser Permanente HMO/Vision ☐ Kaiser Senior Advantage HMO/Vision/Dental ☐ Coresource PPO/Vision Division Name:_____ Division #:_____ Plan Account #:_____ ☐ Medicare Coverage ☐Part A Only ☐Part B Only ☐Parts A&B	*Choose one:* *Rates are noted below coverage level*	(1)☐ Employee only **Kaiser $389.44** **Coresource $500.33** (2)☐ Employee + 1 dependent **Kaiser $389.44** **Coresource $1117.88** (3)☐ Employee + family **Kaiser $1102.11** **Coresource $1679.42**
•DENTAL	*Choose one:*	☐ Delta PPO Dental ☐ UHC DMO Dental ***MUST designate DMO Provider* →	*Choose one:*	(1)☐ Employee only **Delta Dental $118.02** **UHC$46.52** (2)☐ Employee + 1 dependent **Delta Dental $200.62** **UHC $74.44** (3)☐ Employee + family **Delta Dental $306.84** **UHC $113.78**
			******UHC DMO Provider ID#	

4. OTHER HEALTH INSURANCE

1. Is anyone listed eligible for Medicare? Yes No If yes, who?_____
2. 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)
			☐Health ☐Other:_____		
			☐Health ☐Other:_____		
			☐ Health ☐Other:_____		
			☐ Health ☐Other:_____		
			☐ Health ☐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.

6. TERMS AND AGREEMENT:

In exchange for my enrollment, 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.

Employee Signature_____

Date_____

Important Information –General Notice

Initial/General Notice of COBRA rights. Continuation coverage rights under COBRA

Company Name	Peralta Community College District	Address	333 East 8th Street Oakland, CA 94606

Introduction
On April 7, 1986 a Federal Law was enacted (Public Law 99-272, Title X)—The Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end (called "Qualifying Events").

This notice is intended to inform you, your spouse, and dependent child(ren) of your rights and obligations under COBRA should you, your spouse, and dependent child(ren) become covered under your sponsoring employer's group health plan(s). This notice is general in nature. For more information about your rights and obligations under the plan, see your summary plan description or contact your plan administrator. All affected individuals should read this notice carefully and refer to it in the event any action is required. You should retain this notice with other important benefits documents. Since all notices will be sent to your last known address, it is important that your sponsoring employer have your current address. If you or your spouse move, or change your mailing address, you must notify the plan administrator.

What is COBRA Coverage?
If you are a covered employee of the sponsoring employer and you are covered by one or more of their group health plans, you have a right to choose continuation coverage for yourself, your spouse and/or dependent child(ren), if you, your spouse and/or dependent child(ren) lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct).

If you are a covered spouse of an employee covered by the Plan of the sponsoring employer, you have the right to choose continuation coverage for yourself and/or dependent child(ren) if you lose group health coverage for any of the following reasons:

1) *The death of your spouse.*
2) *The termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment with the sponsoring employer.*
3) *Divorce or legal separation from your spouse, or;*
4) *Your spouse becomes entitled to Medicare.*

If you are a covered dependent child of an employee covered by the Plan of the sponsoring employer, you have the right to choose continuation coverage if group health coverage is lost for any of the following reasons:

1) *The death of the employee.*
2) *The termination of the employee's employment (except for terminations due to gross misconduct) or a reduction in the employee's hours of employment with the sponsoring employer.*
3) *Parent's divorce or legal separation.*
4) *The employee becomes entitled to Medicare, or;*
5) *The dependent ceases to be a "dependent child" under the terms of the Plan.*

For retirees, spouses or dependent children of a retiree, you also have a right to elect continuation coverage if you lose coverage within one year before or after your sponsoring employer's commencement of Bankruptcy proceedings under Title 11, United States Code. Under the plan, Qualified Beneficiaries who elect COBRA coverage are required to pay for COBRA continuation coverage.

You must give notice of some Qualifying Events. Under the law, the covered employee or family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the terms of the group health plan within 60 days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later. Written notice must be provided to the Plan Administrator at the address shown on this form. If notice to the Plan Administrator is not made within 60 days, all rights to continuation coverage will terminate. If a covered employee cancels coverage for a spouse in anticipation of a divorce or legal separation, the sponsoring employer, upon receiving timely notification, is required to make COBRA continuation coverage available as of the date of divorce or legal separation, but not before that date. As of January 1, 1997, the term "Qualified Beneficiary" for COBRA purposes also includes a child born to or placed for adoption with a covered employee during the period of the employee's continuation coverage. Once a newborn or adopted child is enrolled in continuation coverage pursuant to the Plan's rules, the child will be treated like all other COBRA Qualified Beneficiaries with respect to the same Qualifying Event. The maximum coverage period for the child is measured from the same date as for other Qualified Beneficiaries with respect to the same Qualifying Event, not from the date of the child's birth or placement for adoption.

The employer has the responsibility to notify the Plan Administrator of Qualifying Events that are the employee's death, termination, reduction of hours in employment, or when a covered employee loses coverage due to Medicare Entitlement, and, if the plan provides retiree health coverage, the commencement of a proceeding in bankruptcy with respect to the employer.

When is COBRA Coverage Available?
When the Plan Administrator is notified that one of these events has happened, you will in turn be notified that you have the right to choose continuation coverage. Under the law, you have 60 days from the later of the 1) date that you would have lost coverage because of the Qualifying Events described above, or 2) the date of the notice of your right to elect continuation coverage, to inform the Plan Administrator that you want continuation coverage. You have 45 days from the date of the election to make your first premium payment. All subsequent premium payments are due on the premium due date, and must be paid in full within the grace period defined by the Plan

(usually 30 days). Payments are considered "made" on the date sent. If you do not choose continuation coverage during this election period, your group health coverage will end according to the terms of the Plan. If you are an incompetent beneficiary, a responsible third party may elect and/or pay for continuation coverage on your behalf. Please provide the Plan Administrator with the following information: (use a separate sheet, if needed)

Employee's Name
Employer's Name
Employee's SS#
Relationship to Employee
Dependent's Name
Dependent's SS#
Dependent's Mailing Address
Dependent's Phone#
Dependent's Date of Birth
Date of Loss of Coverage

If you choose COBRA continuation coverage, you are required to be provided with coverage that is identical to the coverage being provided under the Plan to similarly situated employees or family members. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If group health coverage is lost because of a termination of employment or reduction in hours of employment, the law requires that Qualified Beneficiaries be afforded the opportunity to elect 18 months of COBRA continuation coverage, which is measured from the Qualifying Event date.

For other Qualifying Events, Qualified Beneficiaries other than the covered employee will be afforded the opportunity to elect 36 months of continuation coverage. An 18 month period of continuation coverage may be extended for up to 11 months (for a total of 29 months of continuation coverage) if the Qualified Beneficiary has been determined to be disabled (under Title II or XVI of the Social Security Act) as of the date of the Qualifying Event or within the first 60 days of COBRA continuation coverage. The Qualified Beneficiary must provide written determination of the disability by the Social Security Administration within 60 days of the determination and prior to the end of the 18-month continuation period. The sponsoring employer may charge up to 150% of the applicable premium during the 11-month disability extension. The 11-month extension applies to all disabled and non-disabled Qualified Beneficiaries entitled to continuation coverage as a result of the same Qualifying Event.

Continuation coverage periods of 18 or 29 months may be extended to 36 months for a Qualified Beneficiary other than the covered employee if a second Qualifying Event occurs. A second Qualifying Event may be the death of the employee, divorce, legal separation, employee becoming entitled to Medicare, or a child losing dependent status under the terms of the Plan. To be eligible for the extension the second Qualifying Event must occur during the original 18 or 29 month continuation period and the Plan Administrator must be notified, in writing, within 60 days of the second Qualifying Event.

The law also provides that continuation coverage may be cut short prior to the expiration date of the 18, 29, or 36 month period for any of the following reasons:

1) *Your sponsoring employer no longer provides any group health coverage for any of its employees.*
2) *The premium for your continuation coverage is not paid in a timely manner.*
3) *You first become, after the date of election, covered under any other group health plan, which does not contain a pre-existing condition exclusion or limitation that would apply to the Qualified Beneficiary.*
4) *You first become, after the date of election, entitled to Medicare.*
5) *Coverage has been extended for up to 29 months due to a disability and there has been a final determination that the individual is no longer disabled. You are required to notify the Plan Administrator within 30 days of any such final determination.*

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA law, you will have to pay the applicable premium, plus an administrative fee, if applicable, during the 18 or 36-month period of continuation coverage. However, during the 11-month disability extension, you may be required to pay up to 150% of the applicable premium. The law also says that, at the end of the 18-, 29-, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan if one is provided under the Plan. Also, under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, you may, in certain cases, such as when you exhaust COBRA continuation coverage, have the right to purchase individual health coverage with out being subject to a pre-existing condition exclusion and without having to show evidence of insurability.

Examine Your Policy Carefully

Please examine your options carefully before declining coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

If You Have Questions
This notice is a summary of the law and is general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstances. If you have any questions about COBRA law, or if you have changed marital status, or either you or your spouse has changed addresses, please contact the Plan Administrator at:

Peralta Community College District,
Benefits Office
333 East 8th Street
Oakland, CA 94606

Or, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa