



PERALTA BENEFITS – EVERYONE

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Peralta Community College District Benefits Office

333 East 8th Street
Oakland, CA 94606

2011-2012 Accomplishments:

- Introduced a voluntary long-term care benefit
- Secured over \$300,000 from the Medicare Drug Subsidy Program
- Delivered, co-sponsored, facilitated dozens of employee-centered workshops
- Implemented elements of the Patient Protection and Affordable Care Act
- Re-enrollment of dependents to age 26

A year of changes.....

- The District has introduced a mid-level self-funded medical plan which provides maximum benefits under the exclusive use of the current network for non-emergency services

But what remains the same?

- We are still contracted with Anthem Blue Cross for our self-funded medical plan and Private Health Care Systems (PHCS) for non-California residents.

Health Care Reform

W-2's issued in 2012

If you are retired from Peralta, are covered under our group insurance plan, and return to work at Peralta, we are required to report the value of your insurance on Peralta's issued W-2 document.

Open Enrollment for the Flexible Benefits Plan will occur from

November 1 – November 30, 2012 for the SHORT plan year January 1 – June 30, 2013. Why the change now? We are aligning the plan year to be consistent with our other health plan renewals.

Customer Service

The District Benefits Office provides support for over 200 active and retired employees and their eligible dependents. We encourage the use of District resources and technologies to increase your access to information and service.*

PSW Benefit Resources (for medical, dental, life and disability)

In addition to the Benefits Office, District resources include, but are not limited to: PSW Benefit Resources assists employees and retirees of the District with the resolution of service issues for District-sponsored group medical, dental, life and disability plans. The PSW Benefit Resources customer service team helps with of escalated claims issues with our carriers, clarification of eligibility rules and other compliance and regulatory matters as they arise. **877 866 2623**

MidAmerica Services (for the tax-deferred plans)

MidAmerica assists with the administration of our tax-deferred 403(b) and 457 Plans. If an employee wants to begin, change or transact on a tax-deferred account with Peralta, MidAmerica can help facilitate transactions on behalf of the District. As third-party administrator, MidAmerica's role is to ensure that our employees and the District are in compliance with external regulations affecting tax deferred investments. **800 634 1178**

**See page 9 for other useful resources*

Websites

Website utilization has increased. We've seen an increase of 20% in the number hits on our employee and retiree websites.

- <http://web.peralta.edu/benefits/>
 - Find out more information on our 403(b) & 457 plan administration, third-party administration, and how to transact on current investments
 - Upcoming workshops and events
- www.peralta.pswbenefits.net
 - Direct links to the many district benefit partners
 - Download claim forms
- <http://peraltaretirees.pswbenefits.net>
 - Download Medicare Premium Reimbursement Claim forms
 - Survivor Guidance information

Did you know...













...PSW Benefit Resources has resolved over hundreds of complex issues facing our employees, retirees and their dependents over the last 5 years.

Inside this issue:

- Plan Comparisons, pages 3-5
- Important References and Resources, page 9
- Frequently Asked Questions, pages 10 – 11
- Post-employment District-Paid Benefits, page 21
- Survivor Benefits and Checklist, page 24
- Required Notices, pages 13 – 19
- Glossary of Terms, page 19

Benefits Overview

Fall 2012

Vendor	Information on Vendors
	<p>Kaiser Medical Plan (Health Maintenance Organization - HMO); www.kp.org</p> <ul style="list-style-type: none"> All employees except Local 39 employees <p>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 co-pay for most services.</p> <p>Pharmacy benefits Retail and mail order is covered up to a 100 day supply at a \$10 co-pay for generic formulary or a \$15 co-pay for a brand name formulary.</p> <ul style="list-style-type: none"> Local 39 employees only <p>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 \$15 co-pay for most services.</p> <p>Pharmacy benefits Retail up to 30 day supply at a \$10 generic or \$20 for brand name formulary prescription. Mail order is covered up to a 100 day supply at a \$20 co-pay for generic formulary or a \$30 co-pay for a brand name formulary.</p>
    	<p>Peralta PPO Medical Plans (Preferred Provider Organization - PPO), administered by CoreSource; www.coresource.com</p> <ul style="list-style-type: none"> All employees except Local 39 employees <p>CoreSource is the administrator 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. The PPO provides coverage for routine and major medical services received through network providers. Most office visits are available after a \$10 co-pay per visit.</p> <p>Pharmacy benefits can be accessed through CVS / Caremark. www.caremark.com. Must use contracting pharmacy vendors ONLY! Retail is covered up to a 30 day supply at a \$10 co-pay for generic prescription or a \$15 co-pay for a brand name prescription. Mail order is covered up to a 90 day supply at a \$5 co-pay for either generic or brand name prescriptions.</p> <ul style="list-style-type: none"> Local 39 employees only <p>CoreSource is the administrator 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. The PPO provides coverage for routine and major medical services received through network providers. Most office visits are available after a \$15 co-pay per visit.</p> <p>Pharmacy benefits can be accessed through CVS / Caremark. www.caremark.com. Must use contracting pharmacy vendors ONLY! Retail is covered up to a 30 day supply at a \$10 co-pay for generic prescription or a \$20 co-pay for a brand name prescription. Mail order is covered up to a 100 day supply at a \$20 co-pay for generic prescription or \$30 co-pay for brand name prescription.</p> <p>Vision benefits for all Peralta PPO Plans can be accessed through UnitedHealthcare Vision; www.myuhcvision.com. Participants can receive benefits through the United Healthcare Vision network of providers and can receive out of network benefits within the plan guidelines. Office visit co-pays are \$10 for examinations.</p>
	<p>Delta Dental Plan (Preferred Provider Organization - PPO); www.deltadentalins.com</p> <p>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 26. 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</p> <p>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</p> <p>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>
	<p>Long Term Disability Insurance; www.ing.com</p> <p>If a covered disability prevents you from working for more than 90 calendar days, the District's Long Term Disability plan, through ING, pays a monthly benefit of up to 60% of your base monthly earnings, up to a \$5,000 per month maximum benefit. Benefits are payable while disabled (after all payable sick leave and other available leaves have been exhausted), within certain time limits specified in the policy. PCCD employees do not pay into State Disability Insurance.</p>
	<p>Basic Term Life and Accident (AD&D) Insurance; www.ing.com</p> <p>The District provides, at no cost to the employee, a life insurance benefit through ING equal to 150% of your base salary (subject to a \$100,000 maximum benefit) for employees, \$1,000 for spouses, and \$100 for each dependent (birth to age 6 months) or \$500 for each dependent (from age 6 months to 22 years). The plan includes an amount equal to the life insurance benefit in the case of accidental death, or a percentage of that amount for accidental loss of sight or limb(s). Life insurance terminates when the employee reaches age 66 unless the employee is still actively employed. The plan can be converted to an individual plan at the retiree's expense.</p>
	<p>Voluntary Term Life Insurance; www.cigna.com</p> <p>You may apply for additional (voluntary) insurance up to \$500,000 for you, your spouse and unmarried dependent children. Coverage is guaranteed if you are a new hire and you apply within 31 days of becoming a benefit eligible employee. Late enrollees will be subject to full evidence of good health.</p>

Medical Plan Highlights
Peralta Medical PPO Plans
Kaiser Medical HMO Plan
Effective July 1, 2012 for all active groups (except Local 39)

Plan	Peralta PPO "Traditional" In-Network	Peralta PPO "Traditional" Out-of-Network	Peralta PPO "Lite" In-Network ONLY	Kaiser HMO In-Network ONLY
Calendar Year Deductible: (deductibles cross accumulate)	\$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	\$300 per person; \$900 per family	\$1,500 per person; \$3,000 per family
Lifetime Maximum Benefit:	Unlimited			Unlimited
Pre-Existing Condition	6 months if enrolling when first eligible or 18 months if enrolling anytime thereafter. Limitation may be reduced by prior Creditable Coverage. No pre-existing condition limitations for anyone under the age of 19			None
Network:	California residents access Anthem Blue Cross (www.anthem.com/ca); non-California residents access PHCS (www.phcs.com)	Not applicable	California residents access Anthem Blue Cross (www.anthem.com/ca); non-California residents access PHCS (www.phcs.com)	Kaiser
Physician Office Visits:	\$10 co-pay (deductible waived)	80% of usual and customary fees, after calendar year deductible	\$10 co-pay (deductible waived)	\$10 co-pay
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% of negotiated rates, 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% of negotiated rates, 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 co-pay (deductible waived). Co-pay will be waived if admitted to the hospital.			\$35 co-pay. Co-pay 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 United Healthcare Vision brochure for schedule of Network and non-Network vision benefits (www.myuhcvision.com)			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 co-pay for generic prescription or a \$15 co-pay for a brand name prescription. Mail order is covered up to a 90 day supply at a \$5 co-pay 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 co-pay.			Retail and mail order is covered up to a 100 day supply at a \$10 co-pay for generic formulary or a \$15 co-pay for a brand name formulary.

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,

Medical Plan Highlights
Peralta Medical PPO Plans, Kaiser Medical HMO Plan
Effective July 1, 2012 (for Local 39 only)

Plan	Peralta PPO "Traditional" In-Network	Peralta PPO "Traditional" Out-of-Network	Peralta PPO "Lite" In-Network ONLY	Kaiser HMO In-Network ONLY
Calendar Year Deductible: (deductibles cross accumulate)	\$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	\$300 per person; \$900 per family	\$1,500 per person; \$3,000 per family
Lifetime Maximum Benefit:	Unlimited			Unlimited
Pre-Existing Condition	6 months if enrolling when first eligible or 18 months if enrolling anytime thereafter. Limitation may be reduced by prior Creditable Coverage. No pre-existing condition limitations for anyone under the age of 19			None
Network:	California residents access Anthem Blue Cross (www.anthem.com/ca); non-California residents access PHCS (www.phcs.com)	Not applicable	California residents access Anthem Blue Cross (www.anthem.com/ca); non-California residents access PHCS (www.phcs.com)	Kaiser
Physician Office Visits:	\$15 co-pay (deductible waived)	80% of usual and customary fees, after calendar year deductible	\$15 co-pay (deductible waived)	\$15 co-pay
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% of negotiated rates, 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% of negotiated rates, 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 co-pay (deductible waived). Co-pay will be waived if admitted to the hospital.			\$35 co-pay. Co-pay 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 UnitedHealthcare Vision brochure for schedule of Network and non-Network vision benefits (www.myuhcvision.com)			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 co-pay for generic prescription or a \$20 co-pay for a brand name prescription. Mail order is covered up to a 100 day supply at a \$20 co-pay for either generic or \$30 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 co-pay.			Retail up to 30 day supply at a \$10 generic or \$20 for brand name formulary prescription. Mail order is covered up to a 100 day supply at a \$20 co-pay for generic formulary or a \$40 co-pay for a brand name formulary.

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,



Dental Plan Highlights

Delta Dental PPO Dental Plan – United Healthcare DMO Dental Plan

Effective July 1, 2012



Plan	Delta Dental	United HealthCare
Network:	Delta Dental www.deltadentalins.com Delta Premier Select: Find a dentist Select: Delta Dental Premier	United HealthCare Dental www.myuhc.com Select: "Locate dentist" Select: "dbp of California Pacific Union Dental" DMO Dental Plan (HMO 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 co-pays. Benefits available to children and adults

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

Benefits Matrix

Benefit Matrix	Benefit Classification as Defined by Benefit Program Assignment
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PeopleSoft Benefit Program Coding	PRB-Full Time 39, 1021, Management, Confidential PRA – Peralta Certificated Administrators	PFF – Contract Faculty PTC – Temporary Contract Faculty	PAB – Adjunct Hourly	TCB – Temporary Classified Benefits
Worker’s Compensation	•	•	•	•
Medical *(refer to Monthly Premium & Contribution Table for explanation on costs)	•	•	• *	
Dental	•	•	• (District does not make contributions)	
Employee Assistance Program	•	•		
Flexible Benefits 125, 129	•	•	•	•
Pre-Tax Parking 132	•	•	•	•
Pre-Tax Transportation 132	•	•	•	•
Tax Deferred Annuities – 403 (b)	•	•	•	•
Tax Deferred Annuities – 457	•	•	•	•
Defined Benefit Plans – 401(a) STRS		•	•	
Defined Benefit Plans – 401(a) PERS	•			
Cash Balance			•	
Apple				•
Employer-Paid Term Life	•	•		
Employer-Paid Long-Term Disability	•	•		
Union Dues / Fees	•	•	•	•

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

Benefits for All Active Employees

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 York RSG. Medical services are rendered through the WellComp medical 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 11.416% 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 (refer to the Monthly Contribution Table enclosed).

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. We also offer tax-deferred savings opportunities through the 457 plan. Maximize your tax savings and minimize your tax liability through these plans! Meet with your personal financial planner or tax-preparer to review how these benefits fit into your future planning. Contact Christine Ingoldsby regarding upcoming workshops scheduled for Peralta. She can be reached at 800.660.6291.

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: 0.01600 of any gross salary (plus approved AFT/CFT pass-throughs)
- Hourly Part-time Faculty:
 - \$17.76 for each month of employment for three (3) equated hours or less (plus approved AFT/CFT pass-throughs)
 - \$30.88 for more than three (3) equated hours (plus approved AFT/CFT pass-throughs)
- Local 1021 of the service Employee International Union (www.seiu1021.org)
 - 1.70% of base salary
 - 1.07% of base salary 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 \$8.25.

Reimbursement Programs

KAISER REIMBURSEMENT PROGRAM FOR MAIL ORDER PRESCRIPTONS

Eligibility:	Active and post 07/01/04 retired members of unions, PFT, 1021, 39; confidential and management employees
Frequency of Reimbursement:	Semi Annually (July and January)
Documentation Guidelines:	Complete Kaiser Reimbursement Form and supply receipts (download form at www.peralta.pswbenefits.net under the Medical / Kaiser HMO link)

MEDICARE PART A and/or PART B REIMBURSEMENT PROGRAM

Eligibility:	Retirees & spouses (or domestic partner) over age 65 and paying for Medicare Part A and/or Part B
Frequency of Reimbursement:	Monthly –subject to the timing of our receipt of your documentation.
Documentation Guidelines:	Annual and periodic verification of monthly premium amount, based on retiree’s payment method to Center for Medicare and Medicaid Services (CMS)

KAISER OFFICE VISITS & PRESCRIPTION DRUG CO-PAYS (INCLUDING MAIL ORDER PRESCRIPTION DRUG CO-PAYS)

Eligibility:	Pre July 1, 2004 retirees
Frequency of Reimbursement:	Semi-Annually (July and January)
Documentation Guidelines:	Complete Kaiser Reimbursement Form and supply receipts (download form at www.peralta.pswbenefits.net under the Medical / Kaiser HMO link)

KAISER REIMBURSEMENT PROGRAM FOR MAIL ORDER BRAND NAME PRESCRIPTONS

Eligibility:	Active and post July 1, 2012 Local 39 retirees / employees
Frequency of Reimbursement:	Semi Annually (July and January)
Documentation Guidelines:	Complete Kaiser Reimbursement Form and supply receipts (download form at www.peralta.pswbenefits.net under the Medical / Kaiser HMO link)

Credit Unions

The District has established relationships with the following credit unions. Credit unions offer banking-like services for the benefit of its members. District employees may arrange to have payroll deductions automatically sent to credit unions affiliated with Peralta.

First United Services Credit Union
Alameda Municipal Credit Union
Provident Central Credit Union

Savings Bonds

District employees may arrange to purchase U. S. Savings Bonds, Series EE. Contact the Payroll Office for more information.

Legal Plan

The Pre-paid Legal Service plan offers a variety of legal protection services in the area of will preparation, identity theft protection, landlord/tenant disputes, divorce, adoption and more! PCCD offers the convenience of payroll deduction. Based on your election, the monthly premium ranges from \$15.95 to \$30.90. Contact the Benefits Office or Pre-paid Legal for membership information, 888.206.2978.

Colonial Life

Choosing the right benefits at the right time of your life can be critical. That’s why Colonial Life is committed to making benefits count by helping people better understand their options. Our personal insurance products offer choices to help you better protect yourself and your family members from life’s unexpected turns.

AFLAC-American Family Life Assurance Company of Columbus

Insurance and income replacement products are available to our employees. Products offered by AFLAC include the Personal Accident Indemnity Plan, Personal Cancer Indemnity Plan and more! Take advantage of the convenience of payroll deduction to participate in this plan. Benefits received under AFLAC are in addition to other employer-paid benefits through the Hartford Long-term disability program or Kaiser and CoreSource medical plans administered through Peralta. Contact District Representative Gilbert Beanum, gilbert_beanum@us.aflac.com or call 510.764.9853 for more information.

Important References and Resources

Insurance & Carrier Contact Information

CoreSource Administrator for Self-Funded Medical PPO Plan (www.coresource.com)	Grp. No. 4138	866.280.4120
Caremark Prescription Plan (www.caremark.com)	Grp. No. CS2200	866.644.7527
United Healthcare Vision Plan (www.myuhcvision.com)	Grp. No. 4138	800.638.3120
Kaiser Permanente HMO Plan (www.kaiserpermanente.org)	Grp. No. 65	800.464.4000
Delta PPO Dental Plan (www.deltadentalins.com)	Grp. No. 938	800.765.6003
United Healthcare DMO Dental Plan (www.myuhcdental.com)	Grp. No. Various	800.999.3367
Pension Dynamics Flexible Benefit Plans (www.pensiondynamics.com)	.....	925.956.0505
MHN Employee Assistance Plan (www.mhn.com)	Grp. No. 2112	800.535.4985
ING Life/AD&D/LTD Plans (www.ing-usacom)	Grp. No. 67094-4	800.955.7736
CIGNA Voluntary Life Plan (www.cigna.com)	Grp. No. VTL3249	800.732.1603
ZUK Financial Group (www.zukfinanical.com)	.....	800.660.6291
Mid America (the third party administrator providing authorization on the Districts tax-deferred plan transactions www.mid-america.biz)	.....	800.430.7999
Accumulation Program for Part Time and Limited Service Employees - Apple (www.midamerica.biz)	.....	800.430.7999

Benefits of Belonging to Peralta Community College District

24 Hour Fitness (www.24hourfitness.com)	Corp #97594	818.808.1300 x5563
Club One (www.clubone.com)	.....	510.895.1010
American Family Life Assurance Company of Columbus (AFLAC) (www.aflac.com)	.....	510.764.9853 x702
Colonial	.....	800.858.0355
First United Services Credit Union (www.1stuscu.org)	.....	800.649.0193
Alameda Municipal Credit Union (www.alamedacu.org)	.....	510.523.1514
Provident Central Credit Union (www.providentcu.org)	.....	800.632.4600
PERS (www.calpers.ca.gov)	.....	888.225.7377
STRS (www.calstrs.com)	.....	800.228.5453
PFT/AFT (www.aft.org)	.....	202.879.4400
Local 1021 (www.unionplus.org)	.....	800.472.2005
Engineers 39 (www.unionplus.org)	.....	800.472.2005
PSW Benefit Resources (Benefits Broker) (www.pswbenefits.com)	.....	877.866.2623
Benefits Office (use this number to report an employee or retiree death and for other benefit related issues- benefits@peralta.edu)	.....	510.587.7838

Frequently Asked Questions

Q1: How can I obtain a list of all in-network providers?

A: Locating in-network providers is easy for Both Anthem Blue Cross and PHCS by accessing their websites.

Anthem Blue Cross

- www.anthem.com/ca
- Click on “Find a doctor”
- Answer the questions and click on “search”
- Print your list by clicking on the print button at the top of the page
- Or call **1.866.280.4120**

PHCS (for out-of-state) residents

- www.phcs.com
- Select PHCS Network (PPO) and click on “submit”
- Choose “doctor” or “facility” and click “continue”
- Answer the questions and click “continue”
- Print your list by clicking on “printer friendly” at the top of the page
- Or call **1.800.371.4803**

Q2: How can I be sure that a provider is in the Anthem Blue Cross PPO Network? If I call a provider here in the Bay Area, and they say that they are a part of the Anthem Blue Cross Network, is that enough? Or do I need to call CoreSource? Or Anthem Blue Cross? Or Check a website.

A: You will need to call Anthem Blue Cross and confirm with the doctor that the doctor is a contracted provider at each point of service. (See FAQ 1).

Q3: If I enroll in the PPO “Traditional” Plan and pay premiums while employed, do I continue to pay that premium after I retire?

A: Yes. Currently Benefit Dynamics is our billing agent. The billing process is reviewed during the retirement appointment with the District’s Benefits Office. Because rates change each July 1, you will be notified of new rates within 60 days of a premium change.

Q4: Cash - in - lieu of benefits—What are they?

A: Effective July 1, 2012, District contract & regular benefit eligible employees now have the opportunity to decline Peralta medical and dental coverage and receive \$225 per month in-lieu of medical insurance and \$25 per month in lieu of dental insurance with PCCD. To be eligible, the Benefits office must receive written proof of other comparable group medical and dental insurance. Medicare, COBRA and Individual Health Plans do NOT qualify as other medical insurance coverage.

To enroll in the cash-in-lieu benefit:

1. Obtain written proof of current group health care coverage. The required proof is a letter verifying insurance and a copy of the plan’s Evidence of Coverage (EOC) or Summary Plan Description (SPD); and
2. Submit the written proof to the Benefits Office; and
3. Complete and submit the Waiver of Medical and Dental Insurance Form; and
4. Agree to notify the district within 30 days of loss of coverage under the other plan.

Q5: What determines my eligibility for medical and dental benefits as an active employee?

A: Benefit eligibility is determined by your union affiliation and the number of hours you are expected to work in a permanent or temporary assignment. Full-Time Equivalency (FTE) determines the range of benefits for which the employee is eligible. To be eligible for 100% of the District cost for medical and dental insurance, the employee should have a 1.0 FTE as assigned by the department.

Q6: What happens to my coverage if I get married, have a child or adopt a child?

A. If you experience any of the following events, you have a special enrollment right under the Health Insurance Portability & Accountability Act (HIPAA). You are entitled to elect or change your benefit plans with no late entrant penalties. You must notify the benefits administrator within 30 days of the event.

- Marriage, divorce or legal separation
- Birth, adoption or placement for adoption
- Moving outside of an HMO service area
- Loss of other group coverage

Furthermore, if you are an employee who is eligible for coverage but not enrolled, you shall be eligible to enroll for coverage within 60 days after (a) becoming ineligible for coverage under a Medicaid, Children’s Health Insurance Plan (CHIP); or (b) being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect

to coverage under the plan. Employers that sponsor group health plans must notify employees of any premium assistance that is available to them under a Medicaid or CHIP plan with respect to coverage under the plan.

Q7: What happens if I claim an ineligible dependent on my benefits?

A: If the District, its representatives or benefit carriers suffer any loss or pay any claims because of a false statement contained in any benefit enrollment / change forms or your failure to notify the District of the termination or change of any dependent status (i.e. divorce, termination of domestic partnership, over-age dependent, legal separation), Peralta may bring a civil action to recover its losses, including reasonable attorney fees.

Q8: Who is eligible as a dependent under my benefit plans?

A: Your eligible dependents are as follows:

1. Your spouse;
2. Your domestic partner (please check with the Benefits Administrator, as you may be required to complete an affidavit of domestic partnership); and
3. Your dependent children up to age 26 (including adopted children, and children of your spouse or domestic partner).

Q9: What if there is an error on my paycheck?

A: From time-to-time paycheck deductions are incorrect due to timing of employee changes relative to the payroll deadline. Currently, when matters are brought to the attention of the Benefits Office, we log the customer service issue and track the issue to closure.

Q10: Will my premiums be taken out on a pre-tax basis automatically?

A: Yes. Deductions will be taken on a pre-tax basis unless you instruct us to deduct on an after-tax basis.

Q11: If I elect and enroll in a benefit plan for which premiums are required, am I paying for benefits in advance or arrears?

A: Employee contributions are taken in arrears. This means that you pay for your coverage at the end of the month.

Q12: Domestic Partners & Imputed Income-If I add a domestic partner to the coverage, how is my pay check affected?

A: You can add a domestic partner to your medical and dental insurance. However, the IRS requires that you be taxed on the value of the premium attributable to the domestic partner. In other words, your gross taxable income is increased by the amount of the insurance premium paid on behalf of the domestic partner. Still confusing? Here is an example of imputed income for an employee coverage of a domestic partner on the Kaiser HMO plan:

Two party monthly premium	Single party monthly premium	Amount of imputed income added to monthly gross
\$1,245.27	\$622.64	\$622.63

Q13: How do I change my address with my medical or dental plan?

A: Change of Address forms are available on the Peralta website at <http://web.peralta.edu/hr/hr-documents-forms/>. The form is available in either Word or PDF format. After completing the form, you may return it in one of three ways.

1. Drop it off at the front desk in Human Resources at the District Administrative Center; or
2. Fax it to Human Resources at 510.466.7280 or 510.466.7397; or
3. Mail it to The Peralta Colleges, Human Resources, Attention: Address Changes, 333 East 8th Street, Oakland, CA 94606.

**CUSTOMER SERVICE IS AVAILABLE THROUGH OUR BROKER
DURING THIS IMPORANT TRANSITION
OPEN ENROLLMENT QUESTIONS • PLAN DESIGN QUESTIONS
POST-ENROLLMENT CUSTOMER SERVICE ISSUES
LOGGING, TRACKING, COMPLIANCE AND RESOLUTION THROUGH
PSW BENEFIT RESOURCES: 1.877.866.2623**



Comparison of Governmental 457 Plans to 403(b) Plans

Features	Governmental 457 Plans	403(b) Plans
Contribution Limits	<ul style="list-style-type: none"> • \$17,000 maximum contribution plus catch-up options • 457 limits not coordinated with 403(b) plan 	<ul style="list-style-type: none"> • \$17,000 maximum contribution plus catch-up options • 457 limits not coordinated with 403(b) plan
Early Withdrawal Penalty Tax	None - (normal income tax only)	10% early withdrawal penalty tax may apply under age 59½, plus normal income tax
Eligibility Rules	No discrimination rules apply - employer defines and limits eligibility	Universal Availability Rule non-discrimination apply
Age 50 Catch-Up Option	Total of \$5,500 for all 457 plans of same employer (not available if special catch-up option used)	Total of \$5,500 for all retirement plans of same employer (other than 457), even if special catch-up option used
Special Catch-Up Option	<p>Three years prior to normal retirement age allows the lesser of:</p> <ul style="list-style-type: none"> • Two times current year's normal contribution limit; or • Underutilized limits from past years. 	<p>Fifteen years of service option increases limit by the lesser of:</p> <ul style="list-style-type: none"> • \$3,000 • \$15,000 less additional limit used in past years; or • Excess of \$5,000 times years of service less past elective deferrals.
Purchase Transfer to SRS Service	Available	Available
Distribution Restrictions	<p>Funds cannot be distributed until:</p> <ul style="list-style-type: none"> • Age 70½ while employed • Disability • Severance from employment • Death • Unforeseeable emergency 	<p>Funds cannot be distributed until:</p> <ul style="list-style-type: none"> • Age 59½ while employed • Disability • Severance from employment • Death • Financial hardship
Portability of Plan Funds After Qualifying Event	<p>Funds can be rolled over to:</p> <ul style="list-style-type: none"> • Governmental 457 Plan of another employer • Another 403(b) provider approved in the plan • IRA (Traditional, SEP, SAR-SEP) • Pension, profit sharing, 401(k) 	<p>Funds can be rolled over to:</p> <ul style="list-style-type: none"> • 403(b) TSA approved in the plan • Governmental 457 Plan of another employer • IRA (Traditional, SEP, SAR-SEP) • Pension, profit sharing, 401(k)
Hardship Distributions	<p>Contributions and earnings may be distributed to the extent required for an unforeseeable emergency beyond control of participant, such as:</p> <ul style="list-style-type: none"> • Medical care • Casualty loss • Payments needed to prevent eviction from foreclosure on home. 	<p>Contributions (but not earnings) may be distributed to extent required for a financial hardship even if foreseeable and voluntary, such as:</p> <ul style="list-style-type: none"> • Medical care • Payments needed to prevent eviction from or foreclosure on home • Payment of tuition • Purchase of a home.
Loans	<p>Permitted, with loans from all qualified plans limited to the lesser of:</p> <ul style="list-style-type: none"> • \$50,000 • One half of vested account balance 	<p>Permitted, with loans from all qualified plans limited to the lesser of:</p> <ul style="list-style-type: none"> • \$50,000 • One half of vested account balance
Required Minimum Distribution	RMD rules apply at age 70½ or later, severance from service, and also after death	RMD rules apply at age 70½ or later, severance from service, and also after death

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Emeryville, CA 94608
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Lake Forest, CA 92630
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Medicare—Part D Fact Sheet and Annual Notification

Please review this document carefully.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current PCCD coverage will be affected. If you elect Medicare Part D and are enrolled on the Kaiser Senior Advantage plan, your coverage under the District WILL be canceled and coverage may not be reinstated until the next open enrollment period. If you do decide to join a Medicare drug plan and drop your current PCCD coverage, be aware that you and your dependents will be unable to get this coverage back until the next open enrollment period.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with PCCD and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

For further information call the PCCD Benefits Office at 510.466.7229. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through PCCD changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1.800.MEDICARE 1.800.633.4227. TTY users should call 1.877.486.2048.

If you have limited income and resources, help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213. TTY users should call 1.800.325.0778.

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 5, 2012
Name of Entity/Sender: PCCD District Benefits Office
Phone Number: 510.466.7229

Medicare—Part D Fact Sheet and Annual Notification

Please review this document carefully.

Important Notice from PCCD About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PCCD and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug **coverage is at the end of this notice.**

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PCCD has determined that the prescription drug coverage offered by Kaiser and CoreSource are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Highlights of the 2012 & 2013 Medicare Prescription Drug benefit:

Minimal monthly premium (varies depending on the plan you choose)

- \$320 annual deductible in 2012 will increase to \$325 in 2013.
- Medicare will cover 75% of the drug cost up to \$2,930.00 (annually) in 2012 increasing to \$2,970 (annually) in 2013.
- Any costs between the \$2,930 and \$4,700 re paid for by employee or retiree in 2012 increasing to \$2,970 and \$4,750 in 2013.
- When an employee drug bill exceed \$4,700 in 2012 or \$4,750 in 2013, Medicare will cover 95% of any costs above that ceiling.

Medicare, Kaiser and Caremark Comparison for PCCD Retirees

Benefits	Medicare Part D	Kaiser	Caremark (through CoreSource medical coverage)
Co-pay	25%	\$1 - \$15*	\$1 - \$15*
Deductible	\$320	None	None

*Co-pays are based on formulary determination and whether or not mail order is used.

*The District reimburses co-pays in accordance prevailing Collective Bargaining Agreements.

As you can see, your existing coverage is on average at least as good as standard Medicare prescription drug coverage. You can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

When Can You Join A Medicare Drug Plan?

Although your District-sponsored plans **are better than** the federal Medicare D Plan, we are required to inform you that you can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15th through Dec. 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

Your Rights Under the Women's Health and Cancer Rights Act

All covered family members must read this notice summarizing your rights under the Women's Health and Cancer Rights Act.

What is the Women's Health and Cancer Rights Act?

The Women's Health and Cancer Rights Act (WHCRA) provides protections for mastectomy patients who choose to have breast reconstruction in connection with a mastectomy. The WHCRA applies only to those group health plans and health insurers that cover benefits for mastectomies; *it does not require* health plans to pay for mastectomies. But for plans that do provide coverage for mastectomies, the WHCRA requires coverage for reconstruction as well. According to the U.S. Department of Labor, the WHCRA is not limited to cancer patients; this law should cover anyone seeking reconstruction after a mastectomy for any reason.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses (e.g. breast implant); and
4. Treatment for physical complications of the mastectomy, including lymph edema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. **NOTE: State laws may broaden federal WHCRA rights. Please read your Summary Plan Description or contact our benefits broker, PSW Benefit Resources at 1.877.866.2623, for complete details on your plan benefits.** More information about the WHCRA may be obtained by calling the Employee Benefits Security Administration of the U.S. Department of Labor toll-free at: 1.866.444.3272.

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 May of each year for all other employees.

The District's self-funded plan administered by CoreSource 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 for all eligible participants age 19 and over. 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 Manager; Peralta Community College District; 333 East 8th Street, Oakland, CA 94606; Phone number: 510.466.7229; Email: jseibert@peralta.edu**

Overage Dependent Status (aka Michelle's Law)

This mandate requires an insurance company to continue medical coverage for an overage dependent that is away from school due to a medical leave of absence. This mandate requires that a dependent child's coverage can continue for **12 months** or until the date on which the coverage is scheduled to end according to the terms and conditions of the plan, whichever occurs first. After this time, if the overage dependent is unable to return to school, he or she will need to apply for individual coverage through COBRA, HIPAA or for disabled coverage under the parent/guardian's plan. An employee is required to notify the insurance company **AND** the employer within 30 days before the leave begins if the leave is known about in advance or within 30 days after the start date of an unplanned medical leave of absence. The carrier will also request a signed note from the attending physician stating the medical necessity, the diagnosis code, leave start date (and end date if known) and the physicians name, date and signature.

Statement of Rights Under the Newborns' & Mothers' Health Protection Act

Under Federal law, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child may not be limited to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. Federal law does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In addition, Federal law states that carriers may NOT require providers / members to obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Protected Health Information

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

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 and \$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 510.466.7229, Address: 333 East 8th Street, Oakland, CA 94606.

GENERAL NOTICE OF COBRA CONTINUATION RIGHTS

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is: **Jennifer Seibert, District Benefits Manager, Peralta Community College District, 333 East 8th Street, Oakland CA 94606, (510) 466-7229**

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies; or
- Your spouse's hours of employment are reduced; or
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent – employee dies; or
- The parent – employee's hours of employment are reduced; or
- The parent – employee's employment ends for any reason other than his or her gross misconduct; or
- The parent – employee becomes enrolled in Medicare (Part A, Part B, or both); or
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: **Jennifer Seibert, District Benefits Manager, Peralta Community College District, 333 East 8th Street, Oakland CA 94606, (510) 466-7229.**

In addition, the employee or family member must notify **Peralta Community College District** within 30 days, of the birth to or placement for adoption of a child of an individual receiving continuation coverage. The child born to or placed for adoption is also eligible for coverage. If desired, the parent who is currently a qualified beneficiary may change coverage status from individual coverage to family coverage to add the new child.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is temporary continuation coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B or both) your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation will last up to 36 months.

When the qualifying event is the end of employment or reduction of work hours, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended. *(continued on next page)*

www.peralta.pswbenefits.net

GENERAL NOTICE OF COBRA CONTINUATION RIGHTS (continued)

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of the COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to **Peralta Community College District**.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when the child stops being eligible under the Plan as a dependent child.

*In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to **Peralta Community College District**.*

California Only: Notice to All Terminating Employees Regarding Medi-Cal & HIV/AIDS

The California Department of Health Services will pay health insurance premiums for certain persons who are losing employment and have a high cost medical condition. In order to qualify for the Health Insurance Premium Payment (HIPP) Program, you must meet ALL of the following conditions:

- You must currently be on Medi-Cal.
- Your Medi-Cal Share of Cost, if any, must be of \$200.00 or less.
- You must have an expensive medical condition. The average monthly savings to Medi-Cal from your health insurance must be at least twice the monthly insurance premiums. If you have a Medi-Cal Share of Cost, that amount will be subtracted from your monthly health care costs to determine if paying the premiums is cost effective.
- You must have a current health insurance policy, COBRA continuation policy, or a conversion policy in effect or available at the time of application.
- Your health insurance policy must cover your high cost medical condition.
- Your application must be completed and returned in time for the State of California to process your application and pay your premium.
- Your health insurance policy must not be issued through the California Major Risk Medical Insurance Board.
- You must not be enrolled in a Medi-Cal related prepaid health plan, County Health Initiative, Geographic Managed Care Program, or the county Medical Services Program (CMSP).

NOTE: If an absent parent has been ordered by the court to provide your health insurance, you will not be eligible for the HIPP Program. For more information you may call this toll free number (800) 951-5294.

Persons Disabled with HIV/AIDS

Under the Ryan White Comprehensive AIDS Resource Emergency Act of 1990 (CARE), persons unable to work because of disability due to HIV/AIDS and who are losing their private health insurance may qualify for the Health Insurance Premium Payment (CARE/HIPP) program for up to 12 months if they meet the following criteria:

- Have applied for Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), State Disability Insurance (SDI), or other disability programs;
- Are currently covered by a health insurance plan (COBRA, individual or group), which includes outpatient prescription drug coverage, and HIV related treatment services;
- Are not currently on the AIDS Drug Assistance Program (ADAP);
- Have a total monthly income of no more than 250% of the current federal poverty level and;
- Will be eligible for the Medi-Cal HIPP Program within 12 months.

For additional information on CARE/HIPP, please call the No. Cal AIDS Hotline at (800) 367-2437 (English/Spanish) or the So. Cal AIDS Hotline at (800) 922-2437 (English) and (800) 922-2438 (Multi-Language).

Special Extension Provision

Health Plans issued in California must allow individuals who have exhausted their 18-month COBRA continuation period (or 29 months, in the case of disability), to continue on the group policy for up to an additional 18 months (or an additional 7 months in the case of disability). In order to exercise the coverage continuation rights under the law, an election to purchase the extended coverage must be made in writing by the COBRA participant to the carrier, no later than 30 calendar days prior to the end of the 18-month COBRA continuation period.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact **Jennifer Seibert, District Benefits Manager, Peralta Community College District, 333 East 8th Street, Oakland CA 94606, (510) 466-7229** or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and district EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

www.peralta.pswbenefits.net

Glossary of Terms

APPEALS CONSIDERATION: Clinical review conducted by appropriate independent clinical peers, when a decision not to certify a requested admission, procedure, or service has been appealed. Sometimes referred to as “third level review.”

CASE MANAGEMENT: A collaborative process which accesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs using communication and available resources to promote quality cost-effective outcomes.

CERTIFICATION: A determination by a Utilization Management Organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

CO-PAY: A dollar amount which is applied per service rendered, i.e. per office visit, per confinement, per emergency room visit.

COINSURANCE: The benefit percentage of *covered expenses* payable by the *Plan* for benefits that are provided under the *Plan*. The *coinsurance* is a percentage that is applied to *covered expenses* after the deductible(s) has been met, if applicable.

COSMETIC SURGERY: Surgery for the restoration or reconstruction of body structures directed toward altering appearance (non-medically necessary procedures).

COVERED EXPENSE: Medically necessary services, supplies or treatment that are recommended or provided by a physician, professional provider or covered facility for the treatment of illness or injury and that are not specifically excluded from coverage. Covered expenses shall include specified preventive care services.

CLINICAL REVIEW CRITERIA: The written screens, decision rules, medical protocols, or guidelines used by the Utilization Management Organization as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health benefit plan.

CUSTOMARY AND REASONABLE AMOUNT: The fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is *incurred* and is comparable in severity and nature to the *illness or injury*. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The *customary and reasonable amount* is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term “area” as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges.

EMERGENCY: The sudden onset of an *illness or injury* where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

- Placing the *covered person's* life in jeopardy.
- Causing other serious medical consequences.
- Causing serious impairment to bodily functions.
- Causing serious dysfunction of any bodily organ or part.

PREEXISTING CONDITIONS: An *illness or injury*, which existed within a six month time period before the *covered person's enrollment date* of coverage under this *Plan*. An *illness or injury* is considered to have existed when the *covered person*:
Sought or received professional advice for the *illness or injury*.
Received medical care or treatment for that *illness or injury*.
Received medical supplies, drugs, or medicines for that *illness or injury*.

PREFERRED PROVIDER: A *physician, hospital* or other health care *facility* who has an agreement in effect with the *Preferred Provider Organization* at the time services are rendered. *Preferred providers* agree to accept the *negotiated rate* as payment in full.

PREFERRED PROVIDER ORGANIZATION: An organization who selects and contracts with certain *hospitals, physicians*, and other health care providers to provide *covered persons* services, supplies and treatment at a *negotiated rate*.

PRIMARY PLAN: The group benefit plan that pays benefits first.

SECONDARY PLAN: The group benefit plan that pays benefits second.

Retiree Information

Retirees who are eligible for PERS or STRS retirement benefits upon separation from the District **may be** eligible for:

1. Life-time medical insurance at District cost, eligibility is based on hire date, retirement date and/or PCCD union affiliation
2. Reimbursement of Medicare A & B premiums
3. Life insurance continues until age 66, conversion is available at the retiree's expense
4. Membership in the Peralta Retiree Organization

Peralta Retiree Organization (PRO) is an organization open to membership to all Peralta retirees. PRO was formed in 2004 to provide assistance and representation to and for retirees in matters relating to retirement and to sponsor activities for the general welfare of its members. PRO distributes a periodic newsletter which keeps its membership informed on a variety of District events and activities. Visit the PRO website for more information: www.peraltaretirees.org.



Dental Coverage upon Separation or Retirement from Peralta Service - Here are some options!

Plan/ Regulation			
Criteria	COBRA Regulation <small>(Rates will change on renewal)</small>	Kaiser Permanente Senior Advantage Plan	Assembly Bill 528 Regulation <small>(for Cal STRS retirees)</small>
Who is eligible?	Anyone losing group dental coverage through termination of employment or retirement	A retiree or dependent who is enrolled in the traditional Kaiser and elects to join the Kaiser Senior Advantage Plan	Academics who are retiring from STRS covered employment with PCCD
Who pays the cost?	Employee/former employee	PCCD (if retiree is enrolled on Kaiser Senior Advantage Plan)	Retiree
Duration? How long will coverage last?	As long as payments are made, generally for up to 18 months, other extensions may be possible	For duration of enrollment in the Kaiser Senior Advantage Plan with PCCD	As long as payments are made by the 10th of each current coverage month
Election window	Must elect within 60 days of separation/retirement or termination	Generally within 30 days of reaching Medicare entitlement	Must elect within 60 days upon separation from service, or after exhaustion of COBRA or Cal COBRA (no late entry)
Network	Delta Dental Premier or United Health Care Dental	DeltaCare, a PMI product, limited network	Delta Dental Premier
How to elect?	Complete COBRA election form; make payments	Complete Kaiser Senior Advantage Form	Complete election form; make payments
Group number	938 (Delta Dental) / 04N6328 (UHC)	65	7226
Single	UHC: \$27.48 / Delta: \$75.78	No additional cost to retiree	\$96.53
2 party	UHC: \$43.97 / Delta: \$128.83		\$179.74
3 party	UHC: \$67.00 /Delta \$197.04		\$222.64
Sliding scale benefits?	No	No	Yes Year 1: 70%; Year 2: 80%; Year 3: 90%; Year 4: 100%
Where can you obtain more information?	Combined Evidence of Coverage & Disclosure Form	DeltaCare Dental HMO Program	Carrier Summary
Website location	www.peraltaretirees.pswbenefits.net		www.deltadentalins.com

DURATION OF BENEFITS

How long do medical benefits last after retirement?

If hire date is:	Duration of District-Paid Benefits for Employee & Eligible Dependents	What Happens at Age 65?	Medicare Premium Reimbursement Program	District Guidance
June 30, 2004 or prior	District-paid benefits continue for the duration of the employee's (retiree's) life for both employee and eligible dependents	Employee and eligible dependent(s) apply for Medicare and retain PCCD group coverage 1) If on Our Self-Funded PPO Plan, provide Our Self-Funded PPO Plan card and Medicare card at each point of service 2) If on Kaiser, enroll in Kaiser Senior Advantage	The District will reimburse Medicare premiums paid Medicare premiums are income indexed and vary by each participant's individual circumstance	Collective Bargaining Agreements: •SEIU 1021 (formerly 790) •Peralta Federation of Teachers (PFT) •Stationary Engineers (39) Board Policy
July 1, 2004 and after	District benefits continue until the employee (retiree) reaches age 65	No current wrap around plan in place through Peralta.	Not applicable	

OTHER MEDICAL PLAN FEATURES*

If retirement date is:	Office Co-pays	Prescription Drugs Obtained at a Retail Pharmacy	Deductible	District-Paid Vision Coverage	District-Paid Dental Insurance
June 30, 2004 or prior	Self-Funded PPO Plan: \$0 Kaiser: \$0	Self-Funded PPP Plan: \$1 Kaiser: \$5	Self-Funded PPO Plan: \$0 Kaiser: \$0	Self-Funded PPO Plan: None Kaiser: Available	Self-Funded PPO Plan: None Kaiser: Available with Senior Advantage only
Between July 1, 2004 and June 30, 2012	Self-Funded PPO Plan: \$10 Kaiser: \$10	Self-Funded PPO Plan: \$10 - \$15 Kaiser: \$10 - \$15	Self-Funded PPO Plan: \$100 per person per calendar year (family maximum of three individual deductibles per calendar year) Kaiser: \$0	Self-Funded PPO Plan: Available Kaiser: Available	Self-Funded PPO Plan: None Kaiser: Yes with Senior Advantage only
July 1, 2012 and after	Self-Funded PPO Plan: Traditional:\$10 Lite:\$10 Kaiser: \$10 <i>For Local 39</i> PPO Traditional:\$15 PPO Lite: \$15 Kaiser: \$15	Self-Funded PPO Plan: Traditional: \$10 - \$15 Lite: \$10- \$15 Kaiser: \$10 - \$15 <i>For Local 39</i> PPO Traditional:\$10-\$20 PPO Lite: \$10-\$20 Kaiser: \$10-\$20	Self-Funded PPO Plan: \$100 per person per calendar year (family maximum of three individual deductibles per calendar year) Kaiser: \$0 <i>For Local 39</i> Same as for all others	Self-Funded PPO Plan: Available Kaiser: Available <i>For Local 39</i> Same as for all others	Self-Funded PPO Plan: None Kaiser: Yes with Senior Advantage only <i>For Local 39</i> Same as for all others

*See the Summary Plan Description for specific plan details.

Post-retirement monthly premium costs are determined by:

- District affiliation
- Medical plan enrollment
- Coverage level

Post employment enrollment into the Self Funded PPO Traditional Plan requires monthly payment of premiums.

Post employment enrollment into the Self Funded PPO Lite Plan and/or Kaiser Plan does not require monthly premiums.

Below are some of the most frequently asked questions of active and retired employees who seek guidance on Medicare enrollment. Different Medicare/eligibility rules apply for disabled and end-stage renal disease*.

**Kaiser Permanente Senior Advantage, Our Self-Funded PPO Plan and Medicare
General Guidance for Medicare Coordination with Peralta Group Benefits
Frequently Asked Questions**

(contact the additional resources below regarding your unique circumstances)

	Active	Retired
1. When should I enroll with Kaiser Senior Advantage?	Members can defer Part B of Medicare until retirement. Different rules apply for disabled and End Stage Renal Disease members.	Upon enrollment in Medicare.
2. When should dependents enroll in Kaiser Senior Advantage?	Spouses of active employees can defer Part B of Medicare until retirement. Different rules apply for disabled and End Stage Renal Disease members.	Spouses of retirees should enroll in Senior Advantage by age 65.
3. Who do I contact to enroll with Kaiser Senior Advantage?	Contact Kaiser at 1-800-747-2189	
4. Does Kaiser assess a penalty for late Kaiser Senior Advantage enrollment?	No.	
5. What are the benefits for the retiree who enrolls in the Kaiser Senior Advantage (dental)?	Not applicable.	The Kaiser Senior Advantage plan supplements the Medicare plan and includes dental, vision and hearing aid benefits.
6. When should I enroll with Medicare?	Members can defer Part B of Medicare until retirement. Different rules apply for disabled and End Stage Renal Disease members.	Three (3) months prior to your 65th birthday, or during the Medicare General Enrollment period of January 1 - March 31
7. To who are Medicare premiums paid?	Medicare premiums are normally deducted from Social Security checks or can be paid quarterly to Social Security. Please note: Active employees can defer Part B until retirement.	Medicare premiums are normally deducted from Social Security checks or can be paid quarterly to Social Security.
8. Who is eligible for reimbursement of Medicare premiums?	Not eligible.	Retirees paying into Medicare.
9. Who do I contact to enroll with Medicare?	Contact Social Security 1-800-772-1213	
10. Is there a late entrant penalty with Medicare?	There is no late enrollment penalty for Part B if a member is actively covered under a group plan as a Peralta employee. Members can defer Part B of Medicare until retirement as long as the retiree applies for Medicare within three (3) months of loss of group coverage as an active employee.	If you do not enroll in Medicare upon turning age 65 you may be subject to a 10% penalty for each 12 month period not enrolled in Medicare.
11. What if I am on Our Self-Funded PPO Plan? When should I apply for Medicare B?	Defer until retirement or loss of group coverage as an active employee.	Three (3) months prior to your 65th birthday, or during the Medicare General Enrollment period of January 1 - March 31
12. If I am on Our Self-Funded PPO Plan as a retiree or survivor, will I receive dental under Medicare?	Not applicable.	No.

Additional Resources

- Social Security 1-800-772-1213 www.socialsecurity.gov
- Medicare 1-800-MEDICARE www.medicare.gov
- Kaiser Senior Advantage 1-800-747-2189 www.kp.org
- Benefit Dynamics 1-925-956-0505 www.pensiondynamics.com

*Members who are disabled or diagnosed with End Stage Renal Disease should contact Medicare directly for information on coordination of benefits with the Peralta group plan.

FREQUENTLY ASKED QUESTIONS

1. What determines the surviving spouse’s monthly premium?

The monthly premium for the surviving spouse of a Peralta retiree is based on medical plan enrollment and the Medicare coordination of the insured at the time of the retiree’s death.

1. Can surviving spouses change benefit plans?

Yes, the surviving spouse retains the opportunity to change medical plans during the annual open enrollment window.

2. To who are monthly premiums paid?

Carrier	Premiums are paid to	Address
Our Self-Funded PPO Plan	CoreSource <i>(as our third-party administrator for our self-funded plan)</i>	COBRA Unit #4138 P.O. Box 83301 Lancaster, PA 17608-3301 866.280.4120
Kaiser	Benefit Dynamics	2300 Contra Costa Boulevard, Suite 400 Pleasant Hill, CA 94523 925.956.0505
United Health Care (UBC) Dental		
Delta Dental (Plans 938 & AB 528)		

4. What is Benefit Dynamics?

Benefit Dynamics is the third-party administrator for the District’s

- Medicare Premium Reimbursement Plan
- COBRA benefits
- Flexible benefit plans under IRS codes 105, 125 and 132

5. Are survivors eligible for the Medicare A & B reimbursement program?

Yes, if they coordinate their coverage with a Peralta group plan, pay premiums and provide documentation of the premiums paid, then the survivor continues to be eligible for the program.

6. Are survivors eligible for the Kaiser mail-order reimbursement program?

Yes, reimbursement will be made on a semi-annual basis for eligible expenses.

7. Does Peralta pay premiums for surviving spouses of Peralta retirees?

No.



September 2012



Benefits Spotlight

PRE RETIREMENT CHECKLIST

Within 90 days of Retirement-for counseling and guidance:

- Contact California Public Employees Retirement System (CalPers) about annuity benefits
- Contact California State Teachers Retirement System (CalSTRS) about annuity benefits
- Contact Social Security about income options
- Contact Medicare to inquire about medical options

Within 60 days (after retirement)

- Complete COBRA Election Notice to continue the following benefits beyond retirement effective date:
 - o Dental coverage
 - o Flexible benefit plan participation under Medical and/or dependent Care Reimbursement Account IRS Code 125
 - o Employee Assistance Program

Within 30 days of Retirement

- Inform your department (use guidance in the Collective Bargaining Agreement)
- Complete Universal Benefit Enrollment Form in order to:
 - Confirm your insurance coverage for you and your eligible dependents as a PCCD retiree.
 - Update your beneficiary on file
- Schedule personal appointment with Benefits Office. Bring:
 - Copy of recent paycheck
 - Resignation letter
 - Universal Benefit Enrollment form
 - Collective Bargaining Agreement

POST-RETIREMENT CHECKLIST

Semi-Annually

- Retirees and eligible dependents should submit the Kaiser Reimbursement Form. Reimbursements are processed each July and January.

Annually

- Inform the district's agent (Benefit Dynamics) of your Medicare premium

Within 30 days

- Notify the District of your change of address
- Inform the district's agent of change in Medicare Premium amount

Survivors Checklist

- 1. Notify Benefits Office of retiree's death. Call 510.587.7838 option 5
- 2. Consider enrolling in medical insurance within 60 days of retiree's death
- 3. Pay premiums on a monthly basis
 - o Submit Kaiser Co-pay reimbursement form, if applicable Send annual Medicare premium verification

CHECK OUT YOUR BENEFITS INFORMATION CENTER (BIC)!

To learn more about your welfare benefits, visit your Benefit Information Center (BIC) website:

www.peralta.pswbenefits.net or www.peraltaretires.pswbenefits.net

