



# PERALTA BENEFITS – EVERYONE

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December 20, 2013



## Part time and Hourly Faculty Benefits Open Enrollment Announcement Spring 2014

Current enrollment ends February 28, 2014. Re-enroll or enroll now through Friday, February 21, 2014 for coverage effective March 1, 2014.

This notice is being sent to part time, hourly faculty on record as of December 31, 2013 who may have a Spring 2014 teaching assignment with Peralta. If you are currently enrolled in benefits and do not re-enroll by February 21st, then, COBRA continuation will be sent in early mid March 2014 according to the provision of page 16 of the electronic version of this document. (See page 16 "COBRA Continuation Coverage" of the full Open Enrollment Announcement for more details). Enrollment is optional and voluntary.

**Current Enrollees ~ Coverage is due to end on February 28, 2014**

To continue coverage, re-enrollment is required by **Friday, February 21, 2014 and is not automatic**. There may be coverage interruption during the reinstatement process for completed forms received by PCCD on or after March 1, 2014.

**New Enrollees ~ Enroll by Friday, February 21, 2014** or within 30 days of involuntary loss of other group coverage. Coverage period begins March 1, 2014 and ends August 31, 2014.

In accordance with the PFT 2012 - 2015 Successor Agreement, effective Fall 2014, the Part Time Community College Faculty Health Insurance Program, as defined by the California Education Code Section 87863 and referred to as the "50/50 Medical Plan" shall only apply to and provide the Kaiser Plan. The 100% buy-in plan for part time faculty set forth in Article 22.G will still be available to all hourly faculty, continuing past practice with the 100% buy-in. Enrollment into the Self Funded (PPO Lite or PPO Traditional) plans is available at 100% of the cost.



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

You may be eligible for participation in the District's medical, dental and flexible benefits plan enrollment. "The Benefit Eligibility & Payment Highlights" which outlines the eligibility criteria for the District group insurance plans for which you may be eligible. Cost of coverage is determined by your collective bargaining agreement, the coverage level, and plan selected.

#### **EMPLOYEE CHECKLIST**

(Forms are available online at [www.peralta.pswbenefits.net](http://www.peralta.pswbenefits.net))

- Determine** if you meet the enrollment criteria based upon your Spring 2014 instruction load ~ refer to "The Benefit Eligibility & Payment Highlights" and the Letter of Assignment from the Campus Office of Instruction or Term Workload - Total Term FTE% - sample can be found on the last page of the web version this document. (**see link below**)
- Download enrollment forms from the website:**  
<http://peralta.pswbenefits.net/HourlyFacultyEnrollment/tabid/985/Default.aspx>
- Complete and return** the following forms by **Friday, February 21, 2014**.
  - Peralta Community College District Benefit Checklist (required by PFT Article 22 C-7)
  - Eligibility Affidavit and Instructor Term Workload (if electing medical coverage)
  - Part Time and Hourly Faculty Universal Benefit Enrollment Form
  - Flexible Benefits Plan Enrollment Forms (including Pre-Tax Commuter Forms)

**Note:** No appointment is required to drop off forms. All forms stated above **MUST** be **RETURNED TOGETHER** in order to affect an enrollment for the applicable plans (no exceptions). The Salary Reduction Agreement (SRA) forms for the tax deferred 403 (b) and 457 plans and/or the enrollment form for the Pre-paid Legal plan are NOT subject to the deadline. The SRA and/or Pre-paid Legal Plan enrollment forms for these plans can be returned at anytime.

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

- Visit the plan websites or contact vendors directly - [www.peralta.pswbenefits.net](http://www.peralta.pswbenefits.net)
- Attend the Part Time and Hourly Faculty Open Enrollment Benefits Workshops:
  - On Professional Development Day - 1/15/14 at 3:00pm (Laney D200)
  - 1/28/14 at 10:00am (Benefits Office)
  - 2/20/14 at 3:00pm (Benefits Office)
- Optimum drop in times are Wednesdays and Fridays in the afternoon.



#### **Inside the web edition:**

- **Required Notices** - Medical and Dental Plan Comparisons (Rates and Features) and More!
- **Reference websites and telephone numbers**
- **Commuter Expenses** - The 2014 monthly contribution limit to the Pre-tax Parking Plan (IRS 132) is \$250.00, up from \$245. The 2014 monthly contribution limit to the Pre-tax Transit plan (IRS 132) is \$130, down from \$245. Download your enrollment form from the website <http://peralta.pswbenefits.net> to effect a change in your contribution.
- **RSVP** to <http://retireeducators.org> for the next tax deferred savings workshop with complimentary dinner sponsored by Teachers Pension and Insurance Services @ Crognans-Montclair @ 6pm on January 15, 2014.

Ed. 12/17/2013

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

Customer Service Available  
PCCD Benefits  
PSW Benefit Resources

#### **Websites:**

[web.peralta.edu/benefits](http://web.peralta.edu/benefits)  
[www.peralta.pswbenefits.net](http://www.peralta.pswbenefits.net)

#### **Email:**

[benefits@peralta.edu](mailto:benefits@peralta.edu)

#### **Telephone:**

510.466.7229  
510.587.7838  
877.866.2623

(PSW Benefit Resources)

**New for Spring 2014:  
Open Benefit Solutions to offer  
Voluntary Benefits for  
Part Time Faculty!**

In accordance with the PFT 2012 - 2015 Successor Agreement, effective Fall 2014, the Part Time Community College Faculty Health Insurance Program, as defined by the California Education Code Section 87863 and referred to as the "50/50 Medical Plan" shall only apply to and provide the Kaiser Plan. The 100% buy-in plan for part time faculty set forth in Article 22.G will still be available to all hourly faculty, continuing past practice with the 100% buy-in. Enrollment into the Self Funded (PPO Lite or PPO Traditional) plans is available at 100% of the cost.

Per Affordable Care Act Regulations, Summaries of Benefits and Coverage (SBCs) can be found at:

<http://peralta.pswbenefits.com>

Enrollment forms are also available online or at the PFT Office:

500 5th Avenue, Oakland, CA 94606  
and the PCCD Benefits Office:  
333 East 8th Street, Oakland, CA 94606



**Benefit Eligibility & Payment Highlights**  
**50% / 50% Medical Plan**  
**100% Medical Plan**  
**Spring 2014**



Plan	50% / 50%	100%
<b>Governance / Guidance</b>	California Assembly Bill 420 California Education Code 87860– 87868	
<b>Re-Enrollment Required Each Academic Semester</b>	Yes	
<b>Plan Description</b>	The 50% / 50% medical plan allows the District to contribute 50% of the group insurance premium for medical coverage (the coverage is extended to eligible dependents). The eligible faculty member is responsible for payment of the remaining 50% of the monthly premium through payroll deduction.	The District makes no contribution towards coverage. The faculty member receives the benefit of the PCCD group rate.
<b>Eligibility Requirements</b>	<ol style="list-style-type: none"> <li>1. Be a current employee as a temporary part time faculty member with the PCCD.</li> <li>2. Be ineligible for other group coverage (paid for by another employer).</li> <li>3. Have a Total Term FTE which <b>equals or exceeds</b> 40% of an FTE.</li> </ol>	<ol style="list-style-type: none"> <li>1. Be a current employee as a temporary part time faculty member with the PCCD.</li> <li>2. Be ineligible for other group coverage (paid for by another employer).</li> <li>3. Have a Total Term FTE Workload which is <b>less than</b> 40% of an FTE.</li> </ol>
<b>Payment Schedule (3 months)</b>	March, April, May 2014	
<b>Coverage Duration (6 months)</b>	March 1, 2014 – August 31, 2014	
<b>Payment Method</b>	Through payroll deduction. Personal check in cases where benefit election cost exceeds anticipated earnings. Other payment arrangements are considered on a case by case basis. Please contact the PCCD Benefits Office for additional information.	
<b>Who Can Enroll?</b>	Employee and eligible dependents as set forth by the benefit programs.	
<b>Forms REQUIRED to Complete Enrollment and Comply with Regulations</b>	<ol style="list-style-type: none"> <li>1) Peralta Community College District Benefit Checklist</li> <li>2) Eligibility Affidavit (including Instructor Term Workload)</li> <li>3) Part Time and Hourly Faculty Universal Enrollment Form</li> <li>4) Flexible Benefits Plan Enrollment Forms (&amp; Pre-Tax Commuter Forms) ~ <i>optional</i></li> <li>5) Pre-Tax Commuter Forms ~ <i>optional</i></li> </ol>	
<b>Options of Medical Plans Available</b>	<ul style="list-style-type: none"> <li>• Kaiser</li> <li>• Self-Funded Lite PPO Plan (network through Anthem Blue Cross of California – Prudent Buyer PPO &amp; benefits –in general-<b>NO</b> out-of-network are available, unless there is an emergency)</li> <li>• Self Funded Traditional PPO Plan (network through Anthem Blue Cross of California – Prudent Buyer PPO &amp; benefits out-of-network are available)</li> </ul>	
<b>Dental Enrollment Possible?</b>	Yes, however there is no District contribution. Coverage available through Delta Dental PPO or United HealthCare DMO Dental.	
<b>Forms &amp; Documentation Deadline</b>	<b>Friday, February 21, 2014</b>	



**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](http://www.peralta.pswbenefits.net).

**Medical Plan Highlights**  
**Peralta Medical PPO Plans**  
**Kaiser Medical HMO Plan**  
**Base Rates in effect July 1, 2013 for active PFT groups**

Coverage Level	Peralta PPO "Traditional" Plan		Peralta PPO "Lite" Plan	Kaiser HMO Plan
Single Rate	\$709.22		\$573.76	\$683.77
Two Party Rate	\$1,584.58		\$1,281.92	\$1,367.53
Family Rate	\$2,380.55		\$1,925.87	\$1,935.06
Plan	Peralta PPO "Traditional" In-Network	Peralta PPO "Traditional" Out-of-Network	Peralta PPO "Lite" In-Network ONLY	Kaiser HMO In-Network ONLY
<b>Calendar Year Deductible:</b> (deductibles cross accumulate)	\$100 per person; 3 times individual deductible per family			None
<b>Out of Pocket Maximum:</b>	\$300 per person;  \$900 per family	\$1,000 per person;  \$3,000 per family	<b>\$300 per person;</b>  <b>\$900 per family</b>	\$1,500 per person;  \$3,000 per family
<b>Lifetime Maximum Benefit:</b>	Unlimited			Unlimited
<b>Pre-Existing Condition</b>	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
<b>Network:</b>	Access Anthem Blue Cross ( <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> )	Not applicable	Access Anthem Blue Cross ( <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> )	Kaiser ( <a href="http://www.kp.com">www.kp.com</a> )
<b>Physician Office Visits:</b>	\$10 co-pay (deductible waived)	80% of usual and customary fees, after calendar year deductible	<b>\$10 co-pay (deductible waived)</b>	\$10 co-pay
<b>Diagnostic Testing, X-Rays and Laboratory:</b>	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	<b>100% of negotiated rates, after calendar year deductible</b>	100%
<b>Inpatient Hospitalization:</b>	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	<b>100% of negotiated rates, after calendar year deductible</b>	100%
<b>Pre-Certification of Inpatient Services:</b>	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.
<b>Emergency Room Visits:</b>	\$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.
<b>Out of Area Benefits:</b>	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.
<b>Vision Plan:</b>	<a href="#">See UnitedHealthcare Vision brochure for schedule of Network and Non-Network vision benefits (<a href="http://www.myuhcvision.com">www.myuhcvision.com</a>)</a>			Vision exam covered under medical plan. Materials benefit limited to \$175 allowance per 24 month period.
<b>Prescription Coverage:</b>	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.

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**Dental Plan Highlights**  
**Delta Dental PPO Dental Plan – United Healthcare DMO Dental Plan**  
**EMPLOYEE MONTHLY COSTS – effective 7/1/13**

Dental Monthly Employee Contribution	Delta Dental Rates	United HealthCare Dental Rates
Single Rate	\$73.82	\$26.95
Two Party Rate	\$125.49	\$43.11
Family Rate	\$191.93	\$65.69
Plan	Delta Dental	United HealthCare
<b>Network:</b>	Delta Dental <a href="http://www.deltadentalins.com">www.deltadentalins.com</a> Delta Premier  Select: Find a dentist Select: Delta Dental Premier	United HealthCare Dental <a href="http://www.myuhc.com">www.myuhc.com</a> DMO Dental Plan (HMO plan)  Select: "Locate dentist" Select: "dbp of California Pacific Union Dental"
<b>Out of Network:</b>	Okay, but is limited to Delta Dental's usual & customary fees	Not permitted. Must use United HealthCare Dental dentists ONLY.
<b>Deductible:</b>	None	None
<b>Diagnostic &amp; Preventative Services:</b> (oral examinations, cleanings, x-rays)	<b>Network:</b> 100% of negotiated rate <b>Non-Network:</b> 100% of usual & customary fees; (balance billing may occur)	<b>Network:</b> 100% of United HealthCare fees <b>Non-Network:</b> No coverage available
<b>Basic Services:</b> (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>	<b>Network:</b> 100% of negotiated rate <b>Non-Network:</b> 100% of usual & customary fees; (balance billing may occur)	<b>Network:</b> 100% of United HealthCare fees <b>Non-Network:</b> No coverage available
<b>Crowns, Jackets, Other Cast Restorations</b> ~ <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>	<b>Network:</b> 100% of negotiated rate <b>Non-Network:</b> 100% of usual & customary fees; (balance billing may occur)	<b>Network:</b> 100% of United HealthCare fees <b>Non-Network:</b> No coverage available
<b>Prosthodontic Services:</b> (bridges, partial and full dentures)	<b>Network:</b> 50% of negotiated rate <b>Non-Network:</b> 50% of usual & customary fees; (balance billing may occur)	<b>Network:</b> 100% of United HealthCare fees <b>Non-Network:</b> No coverage available
<b>Calendar Year Maximum (Per Person):</b>	\$1,500	Unlimited
<b>Orthodontia Services:</b>	Dependent <b>children only</b> to age 19; <b>Network:</b> 50% of negotiated rate <b>Non-Network:</b> 50% of usual & customary fees  Benefits limited to a separate \$1,000 per person per calendar year maximum	100% of United HealthCare fees not to exceed \$2,250 in patient copays. Benefits available to <b>children and adults.</b>

**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](http://www.peralta.pswbenefits.net).

## Overview of Benefits Spring 2014

Vendor	Information on Vendors
	<p><b>Kaiser Medical Plan (Health Maintenance Organization ~ HMO); <a href="http://www.kp.org">www.kp.org</a></b></p> <ul style="list-style-type: none"> <li>All employees except Local 39 employees</li> </ul> <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><b>Pharmacy benefits</b> 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>
      	<p><b>Peralta PPO Medical Plans (Preferred Provider Organization - PPO), administered by CoreSource; <a href="http://www.mycourcesource.com">www.mycourcesource.com</a></b></p> <ul style="list-style-type: none"> <li>All employees except Local 39 employees</li> </ul> <p>CoreSource is the administrator of the medical services received through the Anthem Blue Cross network. To access Anthem Blue Cross providers, go to <a href="http://www.anthem.com/ca">www.anthem.com/ca</a>. 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><b>Pharmacy benefits can be accessed through CVS / Caremark. <a href="http://www.caremark.com">www.caremark.com</a>.</b> 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> <p><b>Vision benefits for all Peralta PPO Plans can be accessed through UnitedHealthcare Vision; <a href="http://www.myuhcvision.com">www.myuhcvision.com</a>.</b> 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><b>Delta Dental Plan (Preferred Provider Organization ~ PPO); <a href="http://www.deltadentalins.com">www.deltadentalins.com</a></b></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><b>United HealthCare Dental Plan (Dental Maintenance Organization ~ DMO); <a href="http://www.myuhc.com">www.myuhc.com</a></b></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><b>Flexible Benefits Plan &amp; Pre-Tax Commuting Reimbursement; <a href="http://www.pensiondynamics.com">www.pensiondynamics.com</a></b></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>

# Benefits Matrix

Benefit Matrix	Benefit Classification as Defined by Benefit Program Assignment			
Benefit Eligibility	PRB-Full Time 39, 1021, Management, Confidential PRA – Peralta Certificated Administrators	PFF – Contract Faculty PTC – Temporary Contract Faculty	PAB – Part Time & Hourly Faculty	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 – 401 (a) STRS			•	
Apple – 401(a) PERS				•
Employer-Paid Term Life	•	•		
Employer-Paid Long-Term Disability	•	•		
Union Dues / Fees Except confidential and managers	•	•	•	•

## 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 Southern California Risk Management Associates, Inc. Medical services are rendered through the *Medical Provider Network* with many providers and specialists in the area.

### 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 **11.442%** 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.

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).

### 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](http://www.pft1603.org))
- Regular/Contract/Accelerated Faculty: **0.01610** of any gross salary (plus approved AFT/CFT pass-throughs)
- Hourly Part-time Faculty:
  - \$**17.89** for each month of employment for three (3) equated hours or less (plus approved AFT/CFT pass-throughs)
  - \$**31.13** for more than three (3) equated hours (plus approved AFT/CFT pass-throughs)
- Local 1021 of the service Employee International Union ([www.seiu1021.org](http://www.seiu1021.org))
  - 1.74** 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](http://www.local39.org))

Monthly dues are twice the hourly rate plus **\$13.00**



## Reimbursement Programs

### KAISER REIMBURSEMENT PROGRAM FOR MAIL ORDER PRESCRIPTONS

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

### MEDICARE PART A and/or PART B REIMBURSEMENT PROGRAM

<b>Eligibility:</b>	Retirees & spouses (or domestic partner) over age 65 and paying for Medicare Part A and/or Part B.
<b>Frequency of Reimbursement:</b>	Monthly –subject to the timing of our receipt of your documentation.
<b>Documentation Guidelines:</b>	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)

<b>Eligibility:</b>	Pre July 1, 2004 retirees
<b>Frequency of Reimbursement:</b>	Semi-Annually (July and January)
<b>Documentation Guidelines:</b>	Complete Kaiser Reimbursement Form and supply receipts (download form at <a href="http://www.peralta.pswbenefits.net">www.peralta.pswbenefits.net</a> 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, 888.206.2978 for more information.

## Important References and Resources



## Insurance & Carrier Contact Information

CoreSource Medical PPO Plan ( <a href="http://www.mycourcesource.com">www.mycourcesource.com</a> )	Grp. No. 4138	866.280.4120
Caremark Prescription Plan ( <a href="http://www.caremark.com">www.caremark.com</a> )	Grp. No. CS2200	866.644.7527
United Healthcare Vision Plan ( <a href="http://www.myuhcvision.com">www.myuhcvision.com</a> )	Grp. No. 754439	800.638.3120
Kaiser Permanente HMO Plan ( <a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a> )	Grp. No. 65	800.464.4000
Delta PPO Dental Plan ( <a href="http://www.deltadentalins.com">www.deltadentalins.com</a> ) See page 4 for information on finding a Network provider	Grp. No. 938	800.765.6003
United Healthcare DMO Dental Plan ( <a href="http://www.myuhcdental.com">www.myuhcdental.com</a> ) See page 4 for information on finding a Network provider	Grp. No. Various	800.999.3367
Pension Dynamics Flexible Benefit Plans ( <a href="http://www.pensiondynamics.com">www.pensiondynamics.com</a> )	.....	925.956.0505
MHN Employee Assistance Plan ( <a href="http://www.mhn.com">www.mhn.com</a> )	Grp. No. 2112	800.535.4985
ING Life/AD&D/LTD Plans ( <a href="http://www.ing-usacom">www.ing-usacom</a> )	Grp. No. 67094-4	800.955.7736
CIGNA Voluntary Life Plan ( <a href="http://www.cigna.com">www.cigna.com</a> )	Grp. No. VTL3249	800.732.1603
ZUK Financial Group ( <a href="http://www.zukfinancial.com">www.zukfinancial.com</a> )	.....	800.660.6291
Mid America Third party administrator providing authorization on the Districts tax-deferred plan transactions ( <a href="http://www.mid-america.biz">www.mid-america.biz</a> )	.....	800.430.7999
Accumulation Program for Part Time and Limited Service Employees - Apple ( <a href="http://www.midamerica.biz">www.midamerica.biz</a> )	.....	800.430.7999

## Benefits of Belonging to Peralta Community College District

Club One ( <a href="http://www.clubone.com">www.clubone.com</a> )	Bring in paycheck stub or business card.	510.895.1010
American Family Life Assurance Company of Columbus (AFLAC) ( <a href="http://www.aflac.com">www.aflac.com</a> )	.....	510.764.9853 x702
Colonial	.....	800.858.0355
First United Services Credit Union ( <a href="http://www.1stuscu.org">www.1stuscu.org</a> )	.....	800.649.0193
Alameda Municipal Credit Union ( <a href="http://www.alamedacu.org">www.alamedacu.org</a> )	.....	510.523.1514
Provident Central Credit Union ( <a href="http://www.providentcu.org">www.providentcu.org</a> )	.....	800.632.4600
PERS ( <a href="http://www.calpers.ca.gov">www.calpers.ca.gov</a> )	.....	888.225.7377
STRS ( <a href="http://www.calstrs.com">www.calstrs.com</a> )	.....	800.228.5453
PFT/AFT ( <a href="http://www.aft.org">www.aft.org</a> )	.....	202.879.4400
Local 1021 ( <a href="http://www.unionplus.org">www.unionplus.org</a> )	.....	800.472.2005
Engineers 39 ( <a href="http://www.unionplus.org">www.unionplus.org</a> )	.....	800.472.2005
PSW Benefit Resources (Benefits Broker) ( <a href="http://www.pswbenefits.com">www.pswbenefits.com</a> )	.....	877.866.2623
Benefits Office (use this number to report an employee or retiree death and for other benefit related issues- <a href="mailto:benefits@peralta.edu">benefits@peralta.edu</a> )	.....	510.587.7838 510.466.7229

# Frequently Asked Questions

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

A: Locating in-network providers is easy by accessing the website.

### **Anthem Blue Cross**

- [www.anthem.com/ca](http://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**

## 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, Coresource 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, 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: 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 (if not registered or not “married”). In other words, your gross taxable income is increased by the amount of the insurance premium paid on behalf of the domestic partner. Note, if you are married, you will NOT have imputed income – this section does NOT apply to you. Still confusing? Here is an example of imputed income for coverage of a domestic partner on the Kaiser HMO plan:

Taxation	Two party monthly premium	Single party monthly premium	Amount of imputed income added to monthly gross
Federal	\$1,367.53	\$683.77	\$683.76
California State *	\$1,367.53	\$683.77	\$0 *
California State **	\$1,367.53	\$683.77	\$683.76 **

(\* w/California State Registration of Domestic Partnership form on file with Peralta Community College District)

(\*\* w/out California State Registration of Domestic Partnership form on file with Peralta Community College District)

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 8<sup>th</sup> Street, Oakland, CA 94606

**Q12: 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.

**OPEN ENROLLMENT QUESTIONS • PLAN DESIGN QUESTIONS  
POST-ENROLLMENT CUSTOMER SERVICE ISSUES  
LOGGING, TRACKING, COMPLIANCE AND RESOLUTION THROUGH  
PSW BENEFIT RESOURCES: 1.877.866.2623**

# 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 are retired from Peralta employment, receive prescription drug coverage through the District as a retiree or dependent thereof, and participate in a Medicare drug plan outside of your Peralta group insurance plan, your current PCCD coverage may be affected.

- If you elect Kaiser Senior Advantage, you are automatically signed up for Medicare Part D at the time of your enrollment. All Medicare benefits are assigned to Kaiser when you enroll in Kaiser Senior Advantage. It is possible that you will be responsible for a monthly Medicare Part D premium payment. A small group, fewer than 5% of all people with Medicare, may pay a monthly premium for Medicare Part D coverage based upon their income. This includes Part D coverage you receive from a Medicare Advantage Plan that includes drug coverage. If your modified adjusted gross income as reported on your IRS tax return from two years ago (the most-recent tax return information provided to Social Security by the IRS) is above a certain limit, you'll pay an extra amount in addition to your plan premium. Usually, the extra amount is deducted from your Social Security check. If not, then the responsibility to make this payment is yours. In accordance with Medicare regulations, Kaiser will terminate the prescription drug benefit affiliated with Kaiser Senior Advantage if the Medicare D premium is not paid.
- If you are enrolled in the PCCD, Self-Funded Plan, and elect to sign up for Medicare Part D, your prescription coverage under the District WILL be canceled. If you do decide to join a Medicare drug plan and drop your current PCCD prescription coverage, be aware that you and your dependents will be unable to get this coverage back until the next open enrollment period.

The District does not reimburse the Medicare D premium tax paid by "Higher Income Beneficiaries" as defined by the Social Security Administration. Criteria for the tax assessment can be found in the publication SSA Publication 05-10536 Medicare Premiums: Rules for Higher Income Beneficiaries. <http://www.ssa.gov/pubs/10536.html#a0=-1>

## 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 Medicare Premiums:

Given the complexity of each individual's circumstances, contact Medicare directly regarding the **accuracy** of the tax amount or the **timing** or the **method** of your payments to the Medicare A, B & D programs.

## 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](http://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](http://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: December 16, 2013 -- 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 2014 Medicare Prescription Drug benefit:

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

- \$310 annual deductible
- Medicare will cover 72% of the drug cost up to \$2,850 (annually)
- Any costs between the \$2,850 and \$4,550 are paid for by employee or retiree
- When an employee drug bill exceed \$4,500, 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 Self-Funded medical coverage)
Co-pay	27%	\$1 - \$15*	\$1 - \$15*
Deductible	\$310	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. 15<sup>th</sup> through Dec. 7<sup>th</sup>.

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, contact human resources, 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 year for Part Time & Hourly Faculty employees and in May of each year for all other employees.

The District's self-funded plan administered by CoreSource 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 8<sup>th</sup> Street, Oakland, CA 94606; Phone number: 510.466.7229; Email: [jseibert@peralta.edu](mailto: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 practically 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 8<sup>th</sup> 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 8<sup>th</sup> 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.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

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 8<sup>th</sup> 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](http://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 8<sup>th</sup> 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](http://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](http://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.



# Comparison of Governmental 457 Plan to 403(b) Plan

Features	Governmental 457 Plan	403(b) Plan
Contribution Limits	<ul style="list-style-type: none"> <li>• \$17,500 basic maximum contribution limit</li> <li>• 457 limits not coordinated with 403(b) plan</li> </ul>	<ul style="list-style-type: none"> <li>• \$17,500 basic maximum contribution limit</li> <li>• 403(b) limits not coordinated with 457 Plan</li> </ul>
Early Withdrawal IRS Penalty Tax	None - (normal income tax only)	10% early withdrawal penalty tax may apply under age 59 ½ plus normal income tax
Eligibility Rules	Non-discrimination rules do not apply	Universal Availability Rule non-discrimination apply
Small Balance Distribution	Account balance \$5,000 or less No contributions in the past 24 months	Not Applicable
Age 50 Catch-Up Option	Total of \$5,500 - not permitted if special catch-up option used	Total of \$5,500 – permitted even if special catch-up option used
Special Catch-Up Option	As permitted in the Plan Document, three years prior to Normal Retirement Age stated in the Plan permits contribution of the lesser of: <ul style="list-style-type: none"> <li>• Subject to strict IRS testing</li> <li>• Two times basic limit, subject to underutilized deferrals in past years.</li> </ul>	As permitted in the Plan Document, 15 years of service option increases limit by the lesser of: <ul style="list-style-type: none"> <li>• Subject to strict IRS testing</li> <li>• \$3,000 annually with a \$15,000 lifetime limit</li> </ul>
Purchase Service Credit State Retirement System	Permitted	Permitted
Distribution Restrictions	<ul style="list-style-type: none"> <li>• Severance from employment</li> <li>• Age 70 ½ while employed</li> <li>• Disability or Death</li> <li>• Small Account Balance</li> <li>• Unforeseeable Emergency.</li> </ul>	<ul style="list-style-type: none"> <li>• Severance from employment</li> <li>• Age 59 ½ while employed</li> <li>• Disability or Death</li> <li>• Financial Hardship.</li> </ul>
Portability of Plan Funds After Qualifying Event	Funds can be rolled over to: <ul style="list-style-type: none"> <li>• Governmental 457 Plan of Another Employer</li> <li>• Another 403(b) provider approved in the Plan</li> <li>• IRA (Traditional, SEP, SAR-SEP)</li> <li>• Pension, Profit Sharing, 401(k)</li> </ul>	Funds can be rolled over to: <ul style="list-style-type: none"> <li>• 403(b) TSA approved in the Plan</li> <li>• Governmental 457 Plan of Another Employer</li> <li>• IRA (Traditional, SEP, SAR-SEP)</li> <li>• Pension, Profit Sharing, 401(k)</li> </ul>
Hardship/Unforeseeable Emergency Distributions	Contributions may be distributed to the extent required for an unforeseeable emergency defined by the IRS as a severe financial hardship to you resulting from events such as a sudden and unexpected illness; an accident you or a dependent experience; loss of your property because of casualty; or other similar extraordinary and unforeseen circumstances arising as a result of events beyond your control. Withdrawals are only permitted for limited financial circumstances that must be substantiated.	Contributions may be distributed to the extent required for a financial hardship defined by the IRS as expenses deemed to be immediate and heavy, including: (1) certain medical expenses; (2) purchase of a principal residence; (3) tuition and related educational fees and expenses; (4) prevent eviction from, or foreclosure on, a principal residence; (5) burial or funeral expenses; and (6) certain expenses for the repair of damage to the employee's principal residence. Withdrawals are only permitted for limited financial circumstances that must be substantiated.
Loans	Applies to all accounts and all Plans (403(b) & 457) of the Employer, limited to the lesser of: <ul style="list-style-type: none"> <li>• \$50,000; or</li> <li>• One half of vested account balance</li> </ul>	Applies to all accounts and all Plans (403(b) & 457) of the Employer, limited to the lesser of: <ul style="list-style-type: none"> <li>• \$50,000; or</li> <li>• One half of vested account balance</li> </ul>
Required Minimum Distribution	RMD rules apply at age 70 ½ or later, severance from service, and also after death	RMD rules apply at age 70 ½ or later, severance from service, and also after death

**MidAmerica Administrative & Retirement Solutions, Inc.**  
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 Lakeland, FL 33801  
[www.midamerica.biz](http://www.midamerica.biz)  
 (866) 873-4240



## INSTRUCTOR TERM WORKLOAD SAMPLE: FOR ILLUSTRATIVE PURPOSES ONLY

- ▷ Benefits
- ▷ Compensation
- ▷ Payroll for North America
- ▽ Curriculum Management
  - ▷ Course Catalog
  - ▷ Schedule of Classes
  - ▷ Enrollment Requirements
  - ▷ Combined Sections
  - ▷ Facility and Event Information
  - ▷ Class Roster
- ▽ Instructor/Advisor Information
  - Instructor Schedule
  - Instructor Term Workload
  - Instructor/Advisor Table
  - Instructor Assignment

Workload Definition		Find   View All	First 1 of 11 Last						
Academic Institution:	PCCD1	Peralta Community College Dist	<b>Total Term FTE%</b> 20.00						
Term:	1114	2011 Fall							
Instructor Assignment Class:	TTMP	T-Temporary/Adjunct							
Calculate Workload:	<input checked="" type="checkbox"/>	Assigned FTE %:	67.00						
Limit Workload:	<input checked="" type="checkbox"/>	Instructor Multiplier %:	100						
Workload Assignment		Job Code							
Description	Subject	Catalog Nbr	Section	Class Nbr	Comb Sects ID	Assign Type	Work Load	App Load	Assignment FTE %
ARITHMETIC WORKSHOP II	MATH	291	L1	41277		Lecture	3.00	<input checked="" type="checkbox"/>	20.00

≥40.00 = Peralta pays ½ for medical  
 <40.00 = Peralta pays 0 for medical

### Effective Fall 2014

In accordance with the PFT 2012 – 2015 Successor Agreement, effective Fall 2014, the Part Time Community College Faculty Health Insurance Program, as defined by the California Education Code Section 87863 and referred to as the "50/50 Medical Plan" shall only apply to and provide the Kaiser Plan. The 100% buy-in plan for part time faculty set forth in Article 22.G will still be available to all hourly faculty, continuing past practice with the 100% buy-in. Enrollment into the Self Funded (PPO Lite or PPO Traditional) plans is available at 100% of the cost.