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**Medicare Part D Notice:** If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 12 for more details.
Peralta Benefits Everyone, Wellness Begins With You!

The Peralta Community College District is a prominent employer of the East Bay and proudly offers a competitive benefit package to its employees. As the benefits landscape changes and evolves, so does the complexity of choices requiring more engagement from our employees as consumers of healthcare.

As you read through this Guide, we hope that you find the information helpful. The Benefits Office encourages you and your family take advantage of these many forms of resources

- E-technology
- Website
- Health Risk Assessments
- Videos
- And more

The District Benefits office offers many empowerment opportunities including but not limited to District-sponsored:

- Pre-retirement planning workshops
- Know what you own, grow what you own, protect what you own workshops
- Voluntary informational workshops on topics such as long-term care, wills/trusts/estate planning and more

Based on your responses and engagement, the Benefits Office is proud to emphasize that we now offer weekly benefit orientations which are generally held at the District Benefits office at 3pm each Tuesday, reservation is required by contacting the Benefits Office by calling (510) 466-7229 or email: benefits@peralta.edu. We encourage you to take full advantage of the electronic resources, self-service and self-directed resources available to you through our business partners.

If you are enrolled in a Peralta group medical plan, you and your family can take a **health assessment through Trustmark and Kaiser**. Please visit the Trustmark or Kaiser websites for more information.

Make sure that the beneficiaries on file for your District-paid life insurance are current. Protect what you and your family own. Be engaged and proactive about your estate and financial planning.

Please continue to provide our office feedback. We appreciate your engagement and work tirelessly to incorporate suggestions where possible. Contact us at benefits@peralta.edu or 510.466.7229 for further guidance and assistance.

Please complete the Universal Benefits Enrollment Form under quick link on Benefits Office webpage: web.peralta.edu/benefits/ or contact the Benefits Office to mail the form to you.

While we’ve made every effort to make sure that this guide is accurate and comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how benefits are paid.
Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

AN APPLE A DAY

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

If you have an HMO Plan, having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

USING THE EMERGENCY ROOM

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time.

BE MED WISE!

Always follow your doctor’s and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.
Retiree Information

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

- Continued medical insurance based on hire date, retirement date and/or PCCD union affiliation.
- Reimbursement of Medicare A, B & D premiums.
- Life Insurance continues until age 66, conversion is available at the retiree’s expense.
- Membership in the Peralta Retiree Organization

Peralta Retiree Organization (PRO) is an organization open to membership by all Peralta retirees. PRO was formed in 2004 to provided 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: [web.peralta.edu/benefits/](web.peralta.edu/benefits/)

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>COBRA Regulation (Rates will change on renewal)</th>
<th>Kaiser Permanente Senior Advantage Plan</th>
<th>Assembly Bill 528 Regulation (for Cal STRS Retirees)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who is eligible?</strong></td>
<td>Anyone losing group dental coverage through termination of employment or retirement</td>
<td>A retiree or dependent who is enrollment in the traditional Kaiser and elects to join the Kaiser Senior Advantage Plan</td>
<td>Academicians who are retiring from STRS covered employment with PCCD</td>
</tr>
<tr>
<td><strong>Who pays the cost?</strong></td>
<td>Employee/former employee</td>
<td>PCCD (if retiree is enrolled on Kaiser Senior Advantage Plan)</td>
<td>Retiree</td>
</tr>
<tr>
<td><strong>Duration? How long will coverage last?</strong></td>
<td>As long as payments are made, generally for up to 18 months, other extensions may be possible</td>
<td>For duration of enrollment in the Kaiser Senior Advantage Plan with PCCD</td>
<td>As long as payments are made by the 10th of each current coverage month</td>
</tr>
<tr>
<td><strong>Election window</strong></td>
<td>Must elect within 60 days of separation/retirement or termination</td>
<td>Generally within 30 days of reaching Medicare entitlement</td>
<td>Must elect within 60 days upon separation from service, or after exhaustion of COBRA or Cal-COBA (no late entry)</td>
</tr>
<tr>
<td><strong>Network</strong></td>
<td>Delta Dental Premier or United Health Care Dental</td>
<td>DeltaCare, a PMI product, limited network</td>
<td>Delta Dental Premier</td>
</tr>
<tr>
<td><strong>How to elect?</strong></td>
<td>Complete COBRA election form; make payments</td>
<td>Complete Kaiser Senior Advantage Form</td>
<td>Complete election form; make payments</td>
</tr>
<tr>
<td><strong>Group number</strong></td>
<td>04N6328 (UHC) / 938 (Delta Dental)</td>
<td>65</td>
<td>11504-0002</td>
</tr>
<tr>
<td><strong>Single</strong></td>
<td>UHC: $32.55 / Delta: $65.98</td>
<td>No additional cost to retiree</td>
<td>$107.99</td>
</tr>
<tr>
<td><strong>2 party</strong></td>
<td>UHC: $52.06 / Delta: $112.17</td>
<td></td>
<td>$201.09</td>
</tr>
<tr>
<td><strong>3 Party</strong></td>
<td>UHC: $79.33 / Delta: $171.55</td>
<td></td>
<td>$249.08</td>
</tr>
<tr>
<td><strong>Sliding scale benefits?</strong></td>
<td>No</td>
<td>No</td>
<td>Yes: Year 1: 70%; Year 2: 80%; Year 3: 90%; Year 4: 100%</td>
</tr>
<tr>
<td><strong>Where can you obtain more information?</strong></td>
<td>Combined Evidence of Coverage &amp; Disclosure Form</td>
<td>DeltaCare Dental HMO Program</td>
<td>Carrier Summary</td>
</tr>
<tr>
<td><strong>Website location</strong></td>
<td><a href="web.peralta.edu/benefits/">web.peralta.edu/benefits/</a></td>
<td><a href="www.deltadentalins.com">www.deltadentalins.com</a></td>
<td></td>
</tr>
</tbody>
</table>
### Duration of Benefits

**HOW LONG DO MEDICAL BENEFITS LAST AFTER RETIREMENT?**

<table>
<thead>
<tr>
<th>If hire date is:</th>
<th>Duration of District-Paid Benefits for Employees.</th>
<th>What Happens at Age 65?</th>
<th>Medicare Premium Reimbursement Program</th>
<th>District Guidance</th>
</tr>
</thead>
</table>
| 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 dependents 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 Plan. | The District will reimburse Medicare premium paid  
Medicare premiums are income indexed and vary by each participant’s individual circumstance | Collective Bargaining Agreements:  
SEIU 1021 (formally 790)  
Peralta Federation of Teachers (PFT)  
Stationary Engineers (39)  
Board Policy |
| July 1, 2004 and after | District-paid benefits continue until the employee (retiree) reaches age 65 | No current wrap around plan in place through Peralta.                                      | Not Applicable                        |                   |

### Other Medical Plan Features*

<table>
<thead>
<tr>
<th>If retirement date is:</th>
<th>Office Co-Pays</th>
<th>Prescription Drugs Obtained at a Retail Pharmacy</th>
<th>Deductible</th>
<th>District-Paid Vision</th>
<th>District-Paid Dental</th>
</tr>
</thead>
</table>
| June 30, 2004 or prior       | Self-Funded PPO Traditional Plan: $0  
Kaiser: $0 | Self-Funded PPO Traditional Plan: $1  
Kaiser: $5 | Self-Funded PPO Traditional Plan: $0  
Kaiser: $0 | Self-Funded PPO Traditional Plan: None  
Kaiser: None | Self-Funded PPO Traditional Plan: None  
Kaiser: Available with Senior Advantage only |
| Between July 1, 2004 and June 30, 2012 | Self-Funded PPO Traditional Plan: $10  
Kaiser: $10 | Self-Funded PPO Traditional Plan: $10 - $15  
Kaiser: $10 - $15 | Self-Funded PPO Traditional Plan: $100 per person per calendar year (family maximum of three individual deductibles per calendar year)  
Kaiser: $0 | Self-Funded PPO Traditional Plan: None  
Kaiser: Available through Kaiser | Self-Funded PPO Traditional Plan: None  
Kaiser: Yes with Senior Advantage only |
| July 1, 2012 and after- We no offer three medical plan options  
1. PPO Traditional with in and out of network benefits  
2. PPO Lite with in-network benefits only | Self-Funded PPO:  
Traditional Plan: $10  
Lite: $10  
For Locals 39 and 1021:  
PPO Traditional: $15  
PPO Lite: $15  
Kaiser: $15 | Self-Funded PPO:  
Traditional Plan: $10 - $15  
Lite: $10 - $15  
For Locals 39 and 1021:  
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  
For Locals 39 and 1021:  
Same as for all others | Self-Funded PPO Plan:  
United Health Care Kaiser: Available through Kaiser  
For Locals 39 and 1021:  
Same as for all others | Self-Funded PPO Plan:  
None  
Kaiser: Yes with Senior Advantage only  
For Locals 39 and 1021:  
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.
Surviving Spouse

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. Historical rate matrices can be found on the PCCD website at web.peralta.edu/benefits.

2. Can surviving spouses change benefit plans?

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

3. To who are monthly premiums paid?

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Premiums are paid to</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Self-Funded PPO Plan</td>
<td>Trustmark (as our third-party administrator for our self-funded plan)</td>
<td>COBRA Unit #4138&lt;br&gt;PO BOX 83301&lt;br&gt;Lancaster, PA 17608-3301&lt;br&gt;866.280.4120</td>
</tr>
<tr>
<td>Kaiser</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Health Care (UBC) Dental</td>
<td>Pension Dynamics</td>
<td>2300 Contra Costa Boulevard, Suite 400&lt;br&gt;Pleasant Hill, CA 94523&lt;br&gt;925.956.0505</td>
</tr>
<tr>
<td>Delta Dental (Plans 938 &amp; AB 528)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. What is Pension Dynamics?

Pension 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 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.
<table>
<thead>
<tr>
<th><strong>Kaiser Permanente Senior Advantage, Our Self-Funded PPO Plan and Medicare</strong></th>
<th><strong>If you are Active:</strong></th>
<th><strong>If you are retired from Peralta and remain on a Peralta-Sponsored Group Plan:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When should I enroll with Kaiser Senior Advantage?</td>
<td>Member can defer Part B of Medicare until retirement. Different rules apply for disabled and End Stage Renal Disease members.</td>
<td>Upon enrollment in Medicare.</td>
</tr>
<tr>
<td>2. When should dependents enroll in Kaiser Senior Advantage?</td>
<td>Spouses of active employees can defer Part B of Medicare until retirement. Different rules apply for disabled and End Stage Renal Disease members.</td>
<td>Spouses of retirees should enroll in Senior Advantage by age 65</td>
</tr>
<tr>
<td>3. Who do I contact to enroll with Kaiser Senior Advantage?</td>
<td>Contact Kaiser at 800.747.2189</td>
<td></td>
</tr>
<tr>
<td>4. Does Kaiser assess a penalty for late Kaiser Senior Advantage enrollment?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5. What are the benefits for the retiree who enrolls in the Kaiser Senior Advantage (dental)?</td>
<td>Not Applicable</td>
<td>The Kaiser Senior Advantage plan supplements the Medicare plan and includes dental, vision and hearing aid benefits</td>
</tr>
<tr>
<td>6. When should I enroll with Medicare?</td>
<td>Members can defer Part B of Medicare until retirement. Different rules apply for disabled and End Stage Renal Disease members.</td>
<td>Three (3) months prior to your 65th birthday, or during the Medicare General Enrollment period of January 1 - March 31</td>
</tr>
<tr>
<td>7. To who are Medicare premiums paid?</td>
<td>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.</td>
<td>Medicare premiums are normally deducted from Social Security checks or can be paid quarterly to Social Security.</td>
</tr>
<tr>
<td>9. Who do I contact to enroll with Medicare?</td>
<td>Contact Social Security 800.772.1213</td>
<td></td>
</tr>
<tr>
<td>10. Is there a late entrant penalty with Medicare?</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>11. What if I am on Our Self-Funded PPO Plan? When should I apply for Medicare B?</td>
<td>Defer until retirement or loss of group coverage as an active employee</td>
<td>Three (3) months prior to your 65th birthday, or during the Medicare General Enrollment period of January 1 - March 31</td>
</tr>
<tr>
<td>12. If I am on Our Self-Funded PPO Plan as a retiree or survivor, will I dental under Medicare?</td>
<td>Not Applicable</td>
<td>No.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td>800.772.1213</td>
<td><a href="http://www.socialsecurity.gov">www.socialsecurity.gov</a></td>
</tr>
<tr>
<td>Medicare</td>
<td>800.MEDICARE</td>
<td><a href="http://www.medicare.gov">www.medicare.gov</a></td>
</tr>
<tr>
<td>Kaiser Senior Advantage</td>
<td>800.747.2189</td>
<td><a href="http://www.kp.org">www.kp.org</a></td>
</tr>
<tr>
<td>Pension Dynamics</td>
<td>925.956.0505</td>
<td><a href="http://www.pensiondynamics.com">www.pensiondynamics.com</a></td>
</tr>
</tbody>
</table>

If you are retired, use the self-service feature from PROMT or download and complete the change form found at [https://web.peralta.edu/hr/update-information/](https://web.peralta.edu/hr/update-information/)

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.
For Assistance

Use references for assistance and information:

<table>
<thead>
<tr>
<th>Insurance &amp; Carrier Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Trustmark Administrator for Self-Funded Medical Plan</td>
</tr>
<tr>
<td>CVS Caremark Rx Plan</td>
</tr>
<tr>
<td>Kaiser Permanente HMO Plan</td>
</tr>
<tr>
<td>DeltaCare USA—Offered through Kaiser Senior Advantage Plan</td>
</tr>
<tr>
<td>Delta Dental AB528</td>
</tr>
<tr>
<td>Medicare Reimbursement A, B &amp; D Plan</td>
</tr>
<tr>
<td>Voya Basic Life Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits Belonging to Peralta Community College District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>PERS</td>
</tr>
<tr>
<td>STRS</td>
</tr>
<tr>
<td>PFT/AFT</td>
</tr>
<tr>
<td>Local 1021</td>
</tr>
<tr>
<td>Engineers 39</td>
</tr>
<tr>
<td>Benefits Office (Use this number to report an employee or retiree death and for other benefit-related issues)</td>
</tr>
</tbody>
</table>
Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

BASIC LIFE AND AD&D

Coverage is provided by Voya Financial.

Basic Life Insurance pays your beneficiary a lump sum if you die. The cost of coverage is paid in full by the company.

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. Please contact the Benefit's Office at (510) 466-7229 to update your beneficiary information. Please complete the Universal Benefits Enrollment Form under quick link on the Benefits Office webpage: web.peralta.edu/benefits/ or contact the Benefits Office to mail the form out to you.

<table>
<thead>
<tr>
<th>Retiree Basic Life Amount</th>
<th>1.5 x your basic annual earnings at retirement up to $100,000. Amount is rounded to the next higher $1,000.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retiree Termination</td>
<td>Coverage ends at age 66</td>
</tr>
</tbody>
</table>

Taxes: Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.
## 2020-2021 Self-Funded PPO Plan Rate Matrix for Post 2012 Retirees

<table>
<thead>
<tr>
<th>Medical Coverage (for all employees except Local 39, 1021 and Confederals)</th>
<th>Medical Coverage (for Local 39, 1021 and Confederals)</th>
<th><strong>Retiree Without Medicare Coordination</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Party</td>
<td>Self-Funded PPO Traditional</td>
<td>Self-Funded PPO Traditional</td>
</tr>
<tr>
<td>Retiree Pays</td>
<td>$361.29</td>
<td>$99.66</td>
</tr>
<tr>
<td>Two-Party</td>
<td>Self-Funded PPO Traditional</td>
<td>Self-Funded PPO Traditional</td>
</tr>
<tr>
<td>Retiree Pays</td>
<td>$807.22</td>
<td>$222.68</td>
</tr>
<tr>
<td>Family</td>
<td>Self-Funded PPO Traditional</td>
<td>Self-Funded PPO Traditional</td>
</tr>
<tr>
<td>Retiree Pays</td>
<td>$1,212.69</td>
<td>$334.54</td>
</tr>
</tbody>
</table>

| **Retirees WITH Medicare Coordination** |
|---|---|---|
| Single Party | Self-Funded PPO Traditional | Self-Funded PPO Traditional |
| Retiree Pays | $0.00 | $0.00 |
| Two-Party | Self-Funded PPO Traditional | Self-Funded PPO Traditional |
| Retiree Pays | $0.00 | $0.00 |
| Family | Self-Funded PPO Traditional | Self-Funded PPO Traditional |
| Retiree Pays | $0.00 | $0.00 |

*Currently there is no premium for participating in the PPO Lite Plan or Kaiser HMO. Rates subject to change upon annual renewal or for external compliance.*
MEDICARE PART D NOTICE

Important Notice from The Peralta Community College District 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 Peralta Community College District 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. Peralta Community College District has determined that the prescription drug coverage offered by our plans 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.

When Can You Join Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 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.

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 Peralta Community College District coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Peralta Community College District is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Peralta Community College District prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 the Peralta Community College District 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 October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the office listed below for further information. 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 Peralta Community College District 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. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit 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 (800) MEDICARE or (800) 633-4227. TTY users should call (877) 486-2048.

If you have limited income and resources, extra 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 (800) 772-1213 (TTY (800) 325-0778).

Remember: 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: July 1, 2020
Name of Entity/Sender: Peralta Community College District
Contact-Position/Office: Harizon Odembo – District Benefits Manager
Address: 333 East 8th Street Oakland, CA 94606
Number: (510) 466-7229

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
WOMEN’S HEALTH AND CANCER RIGHTS ACT
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
• All stages of reconstruction of the breast on which the mastectomy was performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance;
• Prostheses; and
• Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS
If you decline enrollment in Peralta Community College District’s health plan for your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Peralta Community College District’s health plan without waiting for the next open enrollment period if you:
• Lose other health insurance or group health plan coverage. You must request enrollment within 30-days after the loss of other coverage.
• Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30-days after the marriage, birth, adoption, or placement for adoption.
• Lose Medicaid or Children’s Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60-days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Peralta Community College District’s health plan if your dependent becomes eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60-days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

NOTICE OF CHOICE OF PROVIDERS
The Kaiser Permanente Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser Permanente designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Kaiser Permanente at 800.464.4000. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Kaiser Permanente or from any other person (including  a
primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser Permanente at 800.464.4000.

NOTICE OF AVAILABILITY OF ALTERNATIVE STANDARD FOR WELLNESS PLAN
Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 510.466.7229 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NONDISCRIMINATION/ACCESSIBILITY REQUIREMENTS NOTICE
Peralta Community College District complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Peralta Community College District does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AVAILABILITY OF SUMMARY INFORMATION
As an employee, the health benefits provided represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Peralta Community College District offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered are available by Benefits office.
PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial (877) KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call (866) 444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Website</th>
<th>Phone</th>
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<tbody>
<tr>
<td>ALABAMA – Medicaid</td>
<td><a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td>1-855-692-5447</td>
</tr>
<tr>
<td>ALASKA – Medicaid</td>
<td>The AK Health Insurance Premium Payment Program</td>
<td><a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
</tr>
<tr>
<td>ARKANSAS – Medicaid</td>
<td><a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
<td>1-855-MyARHIP (855-692-7447)</td>
</tr>
<tr>
<td>CALIFORNIA – Medicaid</td>
<td><a href="https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a></td>
<td>1-800-541-5555</td>
</tr>
<tr>
<td>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</td>
<td><a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td>1-800-221-3943/ State Relay 711</td>
</tr>
<tr>
<td>Florida – Medicaid</td>
<td><a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a></td>
<td>1-877-357-3268</td>
</tr>
<tr>
<td>State</td>
<td>Medicaid Website</td>
<td>Medicaid Phone</td>
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<tr>
<td>GEORGIA</td>
<td>Medicaid Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162 ext. 2131</td>
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<tr>
<td>INDIANA</td>
<td>Healthy Indiana Plan for low-income adults 19-64 Phone: 1-877-438-4479</td>
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<td>IOWA</td>
<td>Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a> Medicaid Phone: 1-800-338-8366</td>
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<tr>
<td>KANSAS</td>
<td>Medicaid Website: <a href="https://www.indianamedicaid.com">https://www.indianamedicaid.com</a> Phone: 1-800-205-8563</td>
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<tr>
<td>KENTUCKY</td>
<td>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: Phone: 1-855-459-6328</td>
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<tr>
<td>LOUISIANA</td>
<td>Medicaid Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> Phone: 1-888-342-6027</td>
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<td>MAINE</td>
<td>Medicaid Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a> Phone: 1-800-442-6003 TTY: Maine relay 711</td>
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<tr>
<td>MASSACHUSETTS</td>
<td>Medicaid and CHIP Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a> Phone: 1-800-862-4840</td>
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<tr>
<td>MINNESOTA</td>
<td>Medicaid Website: <a href="https://www.minnehapankids.org/medicaid/healthcare-programs/programs-and-services/medical-assistance.jsp">https://www.minnehapankids.org/medicaid/healthcare-programs/programs-and-services/medical-assistance.jsp</a> Phone: 1-800-657-3739</td>
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<tr>
<td>MISSOURI</td>
<td>Medicaid Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005</td>
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<tr>
<td>MONTANA</td>
<td>Medicaid Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: (855) 632-7633</td>
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<tr>
<td>NEBRASKA</td>
<td>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Phone: 1-800-992-0900</td>
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<td>NEW HAMPSHIRE</td>
<td>Medicaid Website: <a href="https://www.dhs.nh.gov/oiip/hipp.htm">https://www.dhs.nh.gov/oiip/hipp.htm</a> Phone: 603-271-5218</td>
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Toll free number for the HIPP program: 1-800-852-3345, ext 5218
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid and CHIP</th>
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<tbody>
<tr>
<td>NEW JERSEY</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs">http://www.state.nj.us/humanservices/dmahs</a> clients/medicaid/</td>
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<td></td>
<td>Medicaid Phone: 609-631-2392</td>
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<td>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
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<td>CHIP Phone: 1-800-701-0710</td>
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<td>NEW YORK</td>
<td>Medicaid Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
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<td>Phone: 1-800-541-2831</td>
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<tr>
<td>NORTH CAROLINA</td>
<td>Medicaid Website: <a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a></td>
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<td>Phone: 919-855-4100</td>
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<td>NORTH DAKOTA</td>
<td>Medicaid Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
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<td>Phone: 1-844-854-4825</td>
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<td>OKLAHOMA</td>
<td>Medicaid and CHIP Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
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<td>Phone: 1-888-365-3742</td>
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<td>OREGON</td>
<td>Medicaid and CHIP Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a></td>
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<td><a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a></td>
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<td>Phone: 1-800-699-9075</td>
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<td>PENNSYLVANIA</td>
<td>Medicaid Website: <a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-</a></td>
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<td>Program.aspx</td>
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<td>Phone: 1-800-692-7462</td>
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<td>RHODE ISLAND</td>
<td>Medicaid and CHIP Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a></td>
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<td>Phone: 855-697-4347 or 401-462-0311 (Direct Rite Share Line)</td>
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<td>SOUTH CAROLINA</td>
<td>Medicaid Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a></td>
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<td>Phone: 1-888-549-0820</td>
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<td>SOUTH DAKOTA</td>
<td>Medicaid Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
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<td>Phone: 1-888-828-0059</td>
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<td>TEXAS</td>
<td>Medicaid Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a></td>
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<td>Phone: 1-800-440-0493</td>
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<td>UTAH</td>
<td>Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a></td>
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<td>CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a></td>
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<td>Phone: 1-877-543-7669</td>
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<td>VERMONT</td>
<td>Medicaid Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
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<td>Phone: 1-800-250-8427</td>
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<td>VIRGINIA</td>
<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
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<td>Phone: 1-800-432-5924</td>
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<td>CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
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<td>Phone: 1-855-242-8282</td>
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<tr>
<td>WEST VIRGINIA</td>
<td>Medicaid Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a></td>
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<td>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</td>
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</table>
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:
U.S. Department of Labor U.S. Department of Health and Human Services
Employee Benefits Security Administration Centers for Medicare & Medicaid Services
1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

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 your 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, 2004, and will remain 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 practice and the new terms of our Notice and make the new Notices 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 exist 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 account more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: 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
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: 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

(('[314x34]20[58x708](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 locations, and provide satisfactory explanation how payments will be handled under the alternative means or locations 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 writing 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.
• 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 slops 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: 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.

**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 180 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 submitted 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: 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.
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 (Pension Dynamics) of your Medicare premium

**Within 30-days**

- Notify the District of your change of address
- Notify the District of addition of eligible dependent (new spouse, child)
- Notify the District of the change in dependent eligibility
- Inform the district’s agent of change in Medicare Premium amount

**Survivor’s Checklist**

- Notify Benefits Office of retiree’s death. Please call 510.587.7838
- Consider enrolling in medical insurance within 60-days of retiree’s death
- Pay premiums on a monthly basis
- Submit Kaiser co-pay reimbursement form, if applicable send annual Medicare premium verification
Key Terms / Glossary

**MEDICAL/GENERAL TERMS**

**Allowable Charge** - The most that an in-network provider can charge you for an office visit or service.

**Balance Billing** - Non-network providers are allowed to charge you more than the plan’s allowable charge. This is called Balance Billing.

**Coinsurance** - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

**Copay** - The fee you pay to a provider at the time of service.

**Deductible** - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

**Explanation of Benefits (EOB)** - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

**Family Deductible** - The maximum dollar amount any one family will pay out in individual deductibles in a year.

**Individual Deductible** - The dollar amount a member must pay each year before the plan will pay benefits for covered services.

**In-Network** - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan’s network. In-network services generally cost you less than out-of-network services.

**Out-of-Network** - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plans’ network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

**Out-of-Pocket** - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

**Out-of-Pocket Maximum** – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

**Preventive Care** – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

**Customary and Reasonable** – Any negotiated fee assessed for services, supplies or treatment by a non-preferred provider, or a 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. 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.

**Brand Name Drug** - A drug sold under its tradmarked name. A generic version of the drug may be available.

**Generic Drug** – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

**Dispense as Written (DAW)** - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.
Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Formulary - A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also, called a drug list.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

Diagnostic and Preventive Services – Generally include routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Usual and Customary – The amount paid for a service in a geographic area based on what providers in the area usually charge for the same or similar service.