2021-2022
Benefits Guide

PERALTA COMMUNITY COLLEGE DISTRICT

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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 26 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 2pm each Tuesday, no RSVP is required. 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.

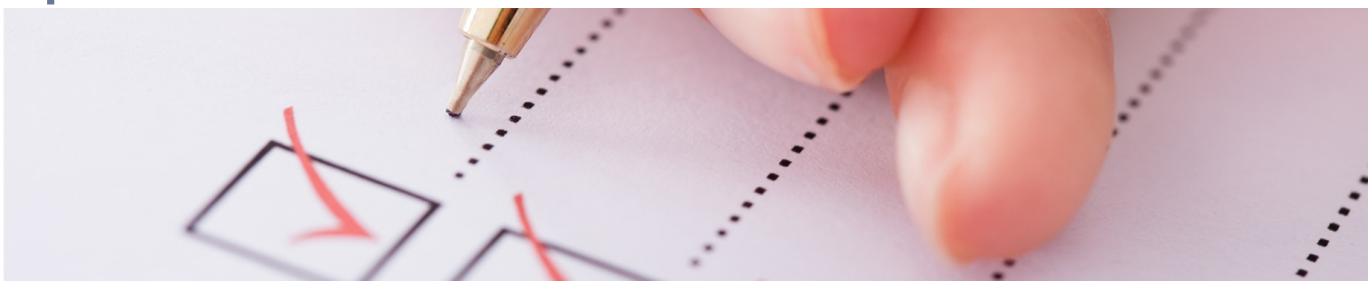
The Employee Assistance Program offers a variety of work-life resources ranging from wellness coaching and personal counselling to legal services

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. Logon to BenefitBridge to view your information and resources.

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.

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.

Open Enrollment



Open Enrollment begins May 1 and ends May 31, 2021. Open enrollment is the annual opportunity for eligible employees/retirees to:

- Change or enroll in eligible benefit plans
- Add or delete a dependent to the group insurance plan

The Peralta Community College District proudly offers a competitive and comprehensive core of work-life benefits. Current benefits for full-time employees include:

- Medical, prescription drug and vision coverage
- Delta Dental PPO dental coverage or United HealthCare DMO dental coverage
- Basic Life and AD&D insurance of 150% of your annual pay up to a $100,000 maximum benefit *(amounts over $50,000 are subject to imputed income per IRS requirement)*
- Voluntary Life Insurance
- Long-term Disability coverage
- Employee Assistance Program
- Voluntary participation in a tax-deferred 403(b) and/or 457(b) plans

TO EFFECT A CHANGE, IF YOU ARE…

- An active employee, submit your enrollment changes on BenefitBridge (see page 24 for additional information on BenefitBridge)
- Retired, on COBRA, or a surviving spouse of a Peralta employee, then submit your change on the Universal Benefit Enrollment Form *(available in District Benefits Office and available online at http://web.peralta.edu/benefits/, under Quick Links)*
- Special note: New benefit eligible employees have 31 calendar days from hire date to enroll in coverage

The benefits in this summary are effective: July 1, 2021 - June 30, 2022

Who Can You Cover?

WHO IS ELIGIBLE?

Full-time employees are eligible for the benefits outlined in this overview. If eligible, you can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same- sex spouse.)
- Your domestic partner, please check with the Benefits Office, as you may be required to complete an affidavit of domestic partnership. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partner. Any premiums for your domestic partner paid for by Peralta Community College District are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children (including your domestic partner's children):
    - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
- Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Family members who are ineligible for coverage include but are not limited to parents, grandparents, and siblings.

WHEN CAN I ENROLL?

Coverage for new full-time employees begins on the 1st of the month following date of hire. New employees who do not make an election within 31 calendar days, subsequently can enroll if they have a qualified life event.

Open enrollment for current full-time employees is generally held in May. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event. Changes outside of open enrollment can be made when there is a qualifying life event.

Make sure to notify Benefits Office Support Services right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 31-days to make your change.

Benefits Matrix

PeopleSoft Benefit Program Coding	PRB – Full Time 39, 1021, Management , Confidential	PFF – Contract Faculty PRA- Peralta Certificated Administrators PTC – Temporary Contract Faculty	PAB – Adjunct Hourly	TCB – Temporary Classified Benefits
Worker's Compensation	X	X	X	X
Medical	X*	X*	X*	
Dental	X*	X*	X* (District does not make contributions)	
Employee Assistance Program	X	X		
Flexible Benefits 125 and 129	X	X	X	X
Pre-Tax Parking 132	X	X	X	X
Pre-Tax Transportation 132	X	X	X	X
Tax Deferred Annuities – 403 (b)	X	X	X	X
Tax Deferred Annuities – 457 (b)	X	X	X	X
Defined Benefit Plans – 401 (a) STRS		X	X	
Defined Benefit Plans – 401 (a) PERS	X			
Cash Balance			X	
Apple				X
Employer-Paid Term Life	X	X		
Employer-Paid Long Term Disability	X	X		
Union Dues/Fees	X	X	X	X

***Please refer to the Monthly Premium & Contribution Matrix or applicable Collective Bargaining Agreement**

Read more about your benefits. Please visit www.benefitbridge.com/peralta

Need help enrolling online? Contact BenefitBridge at 800.814.1862.

Retirees can visit the Peralta benefits website for current information at http://web.peralta.edu/benefits/

Affordable Care Act Update

In compliance with the Affordable Care Act, each month the District is tracking hours of work performed by each employee. If you average 130 hours or more per month over the last 12-months, the District will notify you of your eligibility for District-paid benefits for you and your eligible dependents. We track eligibility on a monthly basis on a rolling 12-month basis. Contact the Peralta District Benefits Office for more information.

Medical

Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

Peralta Community College District gives you a choice between medical plans through Kaiser Permanente Insurance Company and Anthem Blue Cross (self-funded plans are administered by Trustmark).

MEDICAL PLANS FOR: MANAGERS & PFT

	Self-Funded Plans Administered by Trustmark			Kaiser HMO
	Anthem PPO Traditional		Anthem PPO Lite	
	In-Network	Out-Of-Network*	In-Network Only	In-Network Only
Annual Deductible	$100 per individual $300 per family	$100 per individual $300 per family	$100 per individual $300 per family	None
Annual Out-of-Pocket Max	$300 per individual $900 per family	$1,000 per individual $3,000 per family	$300 per individual $900 per family	$1,500 per individual $3,000 per family
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit (Primary or Specialist)	$10 copay	Plan pays 80% after deductible	$10 copay	$10 copay
Preventive Services	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%
Chiropractic Care	Covered	Covered	Covered	Not covered
Lab and X-ray	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 100% after deductible	Plan pays 100%
Inpatient Hospitalization	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 100% after deductible	Plan pays 100%
Outpatient Surgery	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 100% after deductible	$10 copay per procedure
Urgent Care	$10 copay	Plan pays 80% after deductible	$10 copay	$10 copay
Emergency Room	$35 copay (copay waived if admitted)	$35 copay (copay waived if admitted)	$35 copay (copay waived if admitted)	$35 copay

*Please note that when you go out-of-network, your benefits are based on a Customary and Reasonable Fee Schedule after deductible is met.

Finding a Medical Provider

To find a provider in the Anthem PPO network, please visit www.anthem.com/ca and search using the alpha prefix: "KZU" or call 866.280.4120.

To find a Kaiser Permanente provider near you, please visit www.kp.org or call 800.464.4000.

Medical

MEDICAL PLANS FOR: LOCAL 39, 1021 AND CONFIDENTIAL

	Self-Funded Plans Administered by Trustmark			Kaiser HMO
	Anthem PPO Traditional		Anthem PPO Lite	
	In-Network	Out-Of-Network*	In-Network Only	In-Network Only
Annual Deductible	$100 per individual $300 per family	$100 per individual $300 per family	$100 per individual $300 per family	None
Annual Out-of-Pocket Max	$300 per individual $900 per family	$1,000 per individual $3,000 per family	$300 per individual $900 per family	$1,500 per individual $3,000 per family
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit (Primary or Specialist)	$15 copay	Plan pays 80% after deductible	$15 copay	$15 copay
Preventive Services	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%
Chiropractic Care	Covered	Covered	Covered	Not covered
Lab and X-ray	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 100% after deductible	Plan pays 100%
Inpatient Hospitalization	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 100% after deductible	Plan pays 100%
Outpatient Surgery	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 100% after deductible	$15 copay
Urgent Care	$15 copay	Plan pays 80% after deductible	$15 copay	$15 copay
Emergency Room	$35 copay (copay waived if admitted)	$35 copay (copay waived if admitted)	$35 copay (copay waived if admitted)	$35 copay

*Please note that when you go out-of-network, your benefits are based on a Customary and Reasonable Fee Schedule after deductible.

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure.

If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. Here are the prescription drug plans that are offered.

PRESCRIPTION DRUGS PLANS FOR: MANAGERS & PFT

	Self-Funded Plans Administered by CVS Caremark			Kaiser HMO
	Anthem PPO Traditional		Anthem PPO Lite	
	In-Network	Out-Of-Network	In-Network Only	In-Network Only
Pharmacy				
Generic	$10 copay	The covered person must pay the usual copay, plus the difference in cost between the participating and non-participating pharmacy.	$10 copay	$10 copay
Preferred Brand	$15 copay		$15 copay	$15 copay
Non-preferred Brand	$15 copay		$15 copay	$15 copay
Supply Limit	30 days	30 days	30 days	100 days
Mail Order				
Generic	$5 copay	Not covered	$5 copay	$10 copay
Preferred	$5 copay	Not covered	$5 copay	$15 copay
Brand	$5 copay	Not covered	$5 copay	$15 copay
Non-preferred Brand	90 days	Not applicable	90 days	100 days

Prescription Drugs

PRESCRIPTION DRUGS PLANS FOR: LOCAL 39

	Self-Funded Plans Administered by CVS Caremark			Kaiser HMO
	Anthem PPO Traditional		Anthem PPO Lite	
	In-Network	Out-Of-Network	In-Network Only	In-Network Only
Pharmacy				
Generic	$10 copay	The covered person must pay the usual copay, plus the difference in cost between the participating and non-participating pharmacy.	$10 copay	$10 copay
Preferred Brand	$20 copay		$20 copay	$20 copay
Non-preferred Brand	$20 copay		$20 copay	$20 copay
Supply Limit	30 days	30 days	30 days	30 days

PRESCRIPTION DRUGS PLANS FOR: 1021 AND CONFIDENTIAL

	Self-Funded Plans Administered by CVS Caremark			Kaiser HMO
	Anthem PPO Traditional		Anthem PPO Lite	
	In-Network	Out-Of-Network	In-Network Only	In-Network Only
Pharmacy				
Generic	$15 copay	The covered person must pay the usual copay, plus the difference in cost between the participating and non-participating pharmacy.	$15 copay	$10 copay
Preferred Brand	$20 copay		$20 copay	$20 copay
Non-preferred Brand	$20 copay		$20 copay	$20 copay
Supply Limit	30 days	30 days	30 days	30 days

For Mail Order Prescription Drugs:
Please consult with your Collective Bargaining Agreement for additional details and reimbursement eligibility.

Reimbursement Programs

KAISER REIMBURSEMENT PROGRAM FOR MAIL ORDER PRESCRIPTIONS	
Eligibility:	Active and post 07/01/04 retired members of unions, PFT, 1021, 39; confidential and management employees
Frequency of Reimbursement:	Semi Annually (July and January)
Documentation Guidelines:	Complete Kaiser Reimbursement Form and supply receipts (download form at http://web.peralta.edu/benefits/)

KAISER OFFICE VISITS & PRESCRIPTION DRUG CO-PAYS (INCLUDING MAIL ORDER PRESCRIPTION DRUG CO-PAYS)	
Eligibility:	Pre July 1, 2004 retirees only
Frequency of Reimbursement:	Semi-Annually (July and January)
Documentation Guidelines:	Complete Kaiser Reimbursement Form and supply receipts (download form at http://web.peralta.edu/benefits/)

KAISER REIMBURSEMENT PROGRAM FOR MAIL ORDER BRAND NAME PRESCRIPTIONS	
Eligibility:	Active and post July 1, 2012 Local 39/Local 1021 retired employees
Frequency of Reimbursement:	Semi Annually (July and January)
Documentation Guidelines:	Complete Kaiser Reimbursement Form and supply receipts (download form at http://web.peralta.edu/benefits/)

MEDICARE PART A, PART B AND/OR PART D REIMBURSEMENT PROGRAM	
Eligibility:	Pre July 1, 2004, Retirees & spouses (or domestic partner) over age 65that are enrolled and paying in the District Medicare Part A, Part B and/or Part D (Refer to Medical Reimbursement Summary Plan Description - at http://web.peralta.edu/benefits/)
Frequency of Reimbursement:	Monthly – subject to the timing of our receipt of your documentation.
Documentation Guidelines:	Annual and periodic verification of monthly premium amount, based on retiree's payment method to Center for Medicare and Medicaid Services (CMS)

Dental

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Peralta Community College District gives you a choice between two dental plans through United Health Care and Delta Dental of California, both plans provide you with comprehensive coverage.

	United Health Care DHMO	Delta Dental DPPO	
	In-Network Only	In-Network	Out-Of-Network*
Calendar Year Deductible	None	None	None
Annual Plan Maximum	Unlimited	$1,600	$1,500
Waiting Period	None	None	None
Diagnostic and Preventive	Plan pays 100% (see contract for fee schedule)	Plan pays 100%**	Plan pays 100%**
Basic Services			
Fillings	Plan pays 100% (see contract for fee schedule)	Plan pays 100%**	Plan pays 100%**
Root Canals	Plan pays 100% (see contract for fee schedule)	Plan pays 100%**	Plan pays 100%**
Periodontics	Plan pays 100% (see contract for fee schedule)	Plan pays 100%**	Plan pays 100%**
Major Services	Plan pays 100% (see contract for fee schedule)	Plan pays 100%**	Plan pays 100%**
Orthodontic Services			
Orthodontia	$2,250 copay then plan pays 100% (see contract for fee schedule)	Plan pays 50%	Plan pays 50%
Calendar Year Maximum	Unlimited	$1,000	$1,000 (combined with in-network)
Coverage	Adult and Dependent Children Covered to age 26	Dependent children Covered to age 26	Dependent Children Covered to age 26

*Please note that when you go out-of-network, your benefits are based on a Usual and Customary Fee Schedule.
**Plan maximums apply

To Find a Provider

To find an UHC DHMO provider, please visit www.myuhcdental.com or call (800) 999-3367.
To find a Delta Dental provider, please visit www.deltadentalins.com or call (800) 765-6003.

Vision (Bundled with Medical Plans)

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

Peralta Community College District gives you vision insurance coverage choices. All plans provides you with comprehensive coverage.

	Anthem PPO Traditional and Lite Plans only				Kaiser HMO Vision Plan*
	UHC Union Vision Plan – Local 39, 1021 & Confidential		UHC Union Vision Plan – Managers & PFT		
	In-Network	Out-of-Network	In-Network	Out-Of-Network	In-Network Only
Examination Benefit Frequency	$15 copay 1 x every 12 months	Up to $40 In-network limitations apply	$10 copay 1 x every 12 months	Up to $40 In network limitations apply	Plan pays 100% 1 x every 24 months
Materials	Plan pays 100%	See schedule below	Plan pays 100%	See schedule below	Up to $175 towards the purchase price of any or all of the following, not more than once every 24 months
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	Plan pays 100% of basic lens Plan pays 100% of basic lens Plan pays 100% of basic lens 1 x every 12 months	Up to $40 Up to $60 Up to $90 In-network limitations apply	Plan pays 100% of basic lens Plan pays 100% of basic lens Plan pays 100% of basic lens 1 x every 12 months	Up to $40 Up to $60 Up to $90 In-network limitations apply	See Materials above See Materials above See Materials above 1 x every 24 months
Frames Benefit Frequency	Up to $120 1 x every 12 months	Up to $45 In- network limitations apply	Up to $120 1 x every 12 months	Up to $45 In-network limitations apply	See Materials above 1 x every 24 months
Elective Contacts (in-lieu of eyeglasses) Benefit Frequency	Up to $150 1 x every 12 months	Up to $150 1 x every 12 months	Up to $146 1 x every 12 months	Up to $150 1 x every 12 months	See Materials above 1 x every 12 months

*Only available to employees who elected a Kaiser HMO medical plan. In addition to your medical benefits, you have access to vision benefits through Kaiser.

To Find a Provider

Please visit www.myuhcvision.com or call (800) 638-3120.

Voluntary Vision

Here is an overview of our additional voluntary vision plan through Vision Service Plan.

	VSP Vision Choice Plan Additional cost to the employee	
	In-Network	Out-Of-Network
Examination Benefit Frequency	$10 copay 1 x every 12 months	Up to $45 In-network limitations apply
Materials	$25 copay	see schedule below
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 Plan pays 100% of basic lens Plan pays 100% of basic lens Plan pays 100% of basic lens 1 x every 12 months	 Up to $30 Up to $50 Up to $65 In-network limitations apply
Frames Benefit Frequency	Up to $130 1 x every 12 months	Up to $70 In-network limitations apply
Elective Contacts **(in-lieu of eyeglasses)** Benefit Frequency	Up to $130 1 x every 12 months	Up to $105 1 x every 12 months

Your monthly rates for the VSP Vision Plan:	
Employee Only	$10.32
Employee + 1 Dependent	$16.04
Employee + Family	$25.44

To Find a Provider

Please visit www.vsp.com or call (800) 877-7195.

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. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the District.

Active Employee Basic Life and AD&D Amount	**Employee**: 1.5 times your basic annual earnings up to $100,000. Amount is rounded to the next higher $1,000. **Spouse/Domestic Partner**: $1,000 **Children after birth to 6 months**: $100 **Children 6 months to age 19, and full time students to age 23**: $500
Active Employee Age Reduction:	Benefit amount reduces to 65% of original coverage at age 65, and to 50% of original coverage at age 70 (refer to Group Life – Voya)

VOLUNTARY LIFE AND AD&D

Coverage is provided by Voya FinancialNEW!

Voluntary Life and Accidental Death and Dismemberment Insurance allows you to purchase additional life insurance to protect your family's financial security.

Employee Voluntary Life Amount	Benefit: Increments of $10,000 up to $500,000 Guaranteed Issue*: $150,000
Spouse Voluntary Life Amount	Benefit: Increments of $10,000 up to $150,000 Guaranteed Issue*: $50,000
Child(ren) Voluntary	6 months and older: Increments of $2,000 up to $10,000; Under 6 months:$500

**The Guarantee Issue amount is only available for new hires and those newly eligible for the benefit. You will need to complete Evidence of Insurability (EOI) in order to apply to add or increase Voluntary Life Insurance if you are not a new hire or newly eligible for the benefit or increasing more than one increment level at Open Enrollment.*

*****See Benefit Office Support Services for more information***

Evidence of Insurability: Depending on the amount of coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. If Active and enrolled in the Voya Basic Life and AD&D, please update your beneficiary information on benefitbridge.com/Peralta.

For Voluntary Life and AD&D - Please contact the Benefits department to update your beneficiary information.

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.

Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

LONG-TERM DISABILITY INSURANCE

Coverage is provided by Voya Financial.

Long-Term Disability coverage pays you a certain percentage of your income if you are unable to work because an injury or illness prevents you from performing any of your job functions over a long time. It is important to know that benefits are reduced by income from other benefits you might receive while disabled like workers' compensation and Social Security.

If you qualify, long-term disability benefits begin after short-term disability benefits end.

Eligibility:	All active employees working 16+ hours per week
Monthly Benefit Amount	Plan pays up to 60% of your eligible income
Maximum Monthly Benefit	$5,000
Benefits Begin After:	
Class 1&2:	90 days of disability; or the date your benefits under any salary continuance or short term disability plan sponsored by the Policyholder terminate; or the date your accumulated sick leave days provided by the Policyholder are exhausted
Class 3:	90 days of disability
Maximum Payment Period*	To age 65 or SSNRA

*The age at which the disability begins may affect the duration of the benefits.

Other Programs

Here are some other valuable programs that you are eligible to participate in:

EMPLOYEE ASSISTANCE PROGRAM

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through MHN Inc. can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's free.

Help is available 24/7, 365 days a year by telephone at 800.535.4985. Other resources are available online at members.mhn.com. When you log in, enter **"Peralta"** as your user name.

In-person counseling may also be available, depending on the type of help you need. The program allows you and your family/household members up to **seven (7)** Face-to-Face or Telephonic or Web-Video Consultation Sessions per incident.

VOLUNTARY 403(B) & 457(B) 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(b) 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. Other resources include:

- Once you have decided to participate in a tax-deferred plan, contributing is as easy as 1-2-3:
    - Establish an account with an approved vendor. The approved vendor list can be found on the U.S. OMNI & TSACG Compliance Services website at www.tsacg.com
    - Download, complete and submit the salary reduction agreement form (SRA) to TSACG for processing through your Peralta payroll deductions
    - Once elected, then confirm the deduction from your Peralta pay
        - Deadlines are noted on the SRA form

Other Programs

Comparison of Governmental 457(b)

Features	Governmental 457 Plan	403(b) Plan
Contribution Limits Year 2021	$19,500 basic maximum contribution limit 457 Limits not coordinated with 403(b) plan	$19,500 basic maximum contribution limit 403(b)
Early Withdrawal IRS Penalty Tax	None - (normal income tax only)	10% early withdrawal penalty tax may apply under age 59 1/2 plus normal
Eligibility Rules	Non-discrimination rules do not apply	Universal Availability Rule non-discrimination
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 $6,500 annual limit - not permitted if special catch-up option used	Total of $6,500 annual limit. Special catch-up option may be utilized.
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: Subject to strict IRS Testing Two times basic limit; subject to underutilized deferral in past years.	As permitted in the Plan Document, 15 years of service option increases limit by the lesser of: Subject to strict IRS testing
Purchase Service Credit State Retirement System	Permitted	Permitted
Distribution Restrictions	Funds cannot be distributed until: - Age 70 ½ - Severance from employment - Disability - Death; or	Funds cannot be distributed until: - Age 59 ½ - Age 55 and/or severance from employment - Disability - Death; or
Portability of Plan Funds After Qualifying Events	Funds can be rolled over to: Governmental 457 Plan of Another Employer Another 403(b) provider approved in the Plan IRA (traditional, SEP, SAR-SEP) Pension, Profit Sharing, 401(k)	Funds can be rolled over to: 403(b) TSA approved in the Plan Governmental 457 Plan of Another Employer IRA (traditional, SEP, SAR-SEP) Pension, Profit Sharing, 401(k)
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 our 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, 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.
Loans	Applies to all accounts and all Plans (403(b) & 457) of the Employer; limited to the lesser of: $50,000; or One half of vested account balance	Applies to all accounts and all Plans (403(b) & 457) of the Employer; limited to the lesser of: $50,000; or One half of vested account balance
Required Minimum Distribution	RMD rules apply at age 72 or later, severance from service, and also after death	RMD rules apply at age 72 or later, severance from service, and also after death

2021-2022 Monthly Contribution Rate Matrix

- For Active, Benefit-Eligible Employees
- Rates are subject to the outcome of union negotiations
- Complete Table on Benefits Webpage: http://web.peralta.edu/benefits/

	Medical Coverage (for all employees except Local 39, 1021 and Confidential)			Medical Coverage (for Local 39, 1021 and Confidential)		
Single Party Coverage	**Kaiser HMO**	***PPO Lite**	****PPO Traditional**	**Kaiser HMO**	***PPO Lite**	****PPO Traditional**
Employee Pays	$0.00	$15.00	$385.77	$0.00	$15.00	$106.41
Peralta Pays	$787.60	$1,527.53	$1,542.53	$768.40	$1,294.95	$1,309.95
Total Cost	$787.60	$1,542.53	$1,928.30	$768.40	$1,309.95	$1,416.36
Two-Party Coverage	**Kaiser HMO**	***PPO Lite**	****PPO Traditional**	**Kaiser HMO**	***PPO Lite**	****PPO Traditional**
Employee Pays	$0.00	$30.00	$861.91	$0.00	$30.00	$237.78
Peralta Pays	$1,575.19	$3,416.38	$3,446.38	$1,536.80	$2,896.75	$2,926.75
Total Cost	$1,575.19	$3,446.38	$4,308.29	$1,536.80	$2,926.75	$3,164.52
Family Coverage	**Kaiser HMO**	***PPO Lite**	****PPO Traditional**	**Kaiser HMO**	***PPO Lite**	****PPO Traditional**
Employee Pays	$0.00	$45.00	$1,294.85	$0.00	$45.00	$357.20
Peralta Pays	$2,228.89	$5,132.62	$5,177.62	$2,174.58	$4,351.95	$4,396.95
Total Cost	$2,228.89	$5,177.62	$6,472.47	$2,174.58	$4,396.95	$4,754.15

**** PPO Traditional premium is billed to the retiree. The actual premium is based on Medicare coordination. Visit the Peralta District Benefits website for a complete matrix of rates.**

Dental Coverage

Your choice of dental coverage and COBRA continuation options are based on District-affiliation and outcome of union negotiations when applicable

	Delta Dental			United Health Care		
Single Party Coverage	**Managers**	**PFT**	**Local 39, 1021, Confidentials**	**Managers**	**PFT**	**Local 39, 1021, Confidentials**
Employee Pre-tax*	$31.33	Pending Negotiations	Pending Negotiations	$0.00	$0.00	$0.00
Employer Non-Taxable*	$31.91	$31.91	$31.91	$31.91	$31.91	$31.91
Total Cost and/or COBRA Equivalent	$63.24	$63.24	$63.24	$31.91	$31.91	$31.91
Two-Party Coverage	**Managers**	**PFT**	**Local 39, 1021, Confidentials**	**Managers**	**PFT**	**Local 39, 1021, Confidentials**
Employee Pre-tax*	$56.46	Pending Negotiations	Pending Negotiations	$0.00	$0.00	$0.00
Employer Non-Taxable*	$51.04	$51.04	$51.04	$51.04	$51.04	$51.04
Total Cost and/or COBRA Equivalent	$107.50	$107.50	$107.50	$51.04	$51.04	$51.04
Family Coverage	**Managers**	**PFT**	**Local 39, 1021, Confidentials**	**Managers**	**PFT**	**Local 39, 1021, Confidentials**
Employee Pre-tax*	$86.65	Pending Negotiations	Pending Negotiations	$0.00	$0.00	$0.00
Employer Non-Taxable*	$77.77	$77.77	$77.77	$77.77	$77.77	$77.77
Total Cost and/or COBRA Equivalent	$164.42	$164.42	$164.42	$77.77	$77.77	$77.77

*Designation as it appears on the Peralta pay advices.

2021-2022 Self-Funded PPO Plan Rate Matrix

FOR POST 2012 RETIREES

Retiree Without Medicare Coordination*		
Medical Coverage (for all employees except Local 39, 1021 and Confidentials)		**Medical Coverage (for Local 39, 1021 and Confidentials)**
Single Party	**Self-Funded PPO Traditional**	**Self-Funded PPO Traditional**
Retiree Pays	$385.77	$106.41
Two-Party	**Self-Funded PPO Traditional**	**Self-Funded PPO Traditional**
Retiree Pays	$861.91	$237.78
Family	**Self-Funded PPO Traditional**	**Self-Funded PPO Traditional**
Retiree Pays	$1,294.85	$357.20

Retirees WITH Medicare Coordination*		
Medical Coverage (for all employees except Local 39, 1021 and Confidentials)		**Medical Coverage (for Local 39, 1021 and Confidentials)**
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

For Assistance

Use references for assistance and information:

Insurance & Carrier Contact Information			
Carrier	Website	Group Number	Phone Number
Trustmark Administrator for Self-Funded Medical Plan	www.mytrustmarkbenefits.com	4138	866.280.4120
CVS Caremark Rx Plan	www.caremark.com	CS2200	866.644.7527
United Healthcare Vision Plan	www.myuhcvision.com	754439	800.638.3120
Kaiser Permanente HMO Plan	www.kp.org	65	800.464.4000
Delta Dental PPO Dental Plan	www.deltadentalins.com	938	800.765.6003
United Healthcare Dental DMO Plan	www.myuhcdental.com	Varies	800.999.3367
CBIZ Flexible Benefit Plans *(formerly Pension Dynamics)*	www.cbiz.com	N/A	925.956.0505
MHN Employee Assistance Program	www.members.mhn.com	2112	800.535.4985
Voya Basic and Supplemental Life/AD&D and LTD Plans	www.voya.com www.voya.com/claims	67094-4	800.955.7736
U.S. OMNI & TSACG Compliance Services *(formerly TSACG)* 403(b) & 457(b) Plans	www.tsacg.com	N/A	888.796.3786
Mid-America TPA for APPLE Accumulation Program for Part Time and Limited Service Employees	www.midamerica.biz	N/A	800.430.7999
Benefits Belonging to Peralta Community College District			
Vision Service Plan	www.vsp.com	N/A	800.877.7195
Alameda Municipal Credit Union	www.alamedacu.org	N/A	510.523.1514
PERS	www.calpers.ca.gov	N/A	888.225.7377
STRS	www.calstrs.com	N/A	800.2285453
PFT/AFT	www.aft.org	N/A	202.879.4400
Local 1021	www.unionplus.org	N/A	800.472.2005
Engineers 39	www.unionplus.org	N/A	800.472.2005
BenefitBridge Technical Support	www.benefitbridge.com/Peralta	N/A	800.814.1862
Benefits Office (Use this number to report an employee or retiree death and for other benefit-related issues)	benefits@peralta.edu	N/A	510.466.7229

Frequently Asked Questions

Q1. When or how can I enroll in medical and dental benefits?

A: Please see page 4 for "who is eligible" and page 25 for Benefit Bridge online enrollment guidance of this Guide.

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 Trustmark? 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 Q1).
- To find a provider in the Anthem PPO network, please visit www.anthem.com/ca and search using the alpha prefix: "KZU" or call 866.280.4120.

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 Trustmark is our billing agent. The billing process is reviewed during the retirement appointment with the District's Benefits Office. Rates change each July 1, generally, you will be notified of new rates within 60-days of a premium change. Please see page 18-19 for the rate matrix. Post-retirement contribution rates are subject to Medicare enrollment and coordination.

Q4: What happens to my coverage if I get married, enter a domestic partnership, 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 31-days of the event by completing a Universal Benefit Enrollment Form if retired or via BenefitBridge if active** (www.benefitbridge.com/peralta)

- 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. For additional information, please reference page 31 HIPAA Notice of Special Enrollment Rights.

Q5: 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.

Q6: Who is eligible as a dependent under my benefit plans?

A: Your eligible dependents are as follows:

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

Q7: Can I switch medical plans when I get married?

A: Yes, you may switch medical plans when you get married. Marriage is an official change in status by the IRS and allows you to enroll for the first time, add or drop dependents or change your plan elections altogether.
These changes must be done within 31-days of your marriage (qualifying event).

Q8: What if there is an error on my paycheck?

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

Q9: 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.

Q10: If I elect and enroll in a benefit plan for which premiums are required, am I paying for benefits in advance or arrears?

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

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. In other words, your gross taxable income is increased by the amount of the insurance premium paid on behalf of the domestic partner. Still confusing? Here is an example of imputed income for an employee coverage of a domestic partner on the Kaiser HMO plan:

Kaiser Permanente HMO $15 Copay Plan			
Taxation	**Two-Party Monthly Premium**	**Single Party Monthly Premium**	**Amount of imputed income added to monthly**
Federal	$1,575.19	$787.60	$787.59
California State*	$1,575.19	$787.60	$0.00*
California State**	$1,575.19	$787.60	$787.59**

*with California State Registration of Domestic Partnership form on file with Peralta Community College District

**without California State Registration of Domestic Partnership form on file with Peralta Community College District

If you have questions, please contact a tax professional about imputed income.

If you have questions about prevailing rates, please contact the Benefits Office at benefits@peralta.edu.

Q12: What is a Qualifying Event?

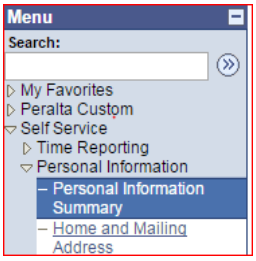
A: Benefit plans can be affected by life event changes, some of which qualify as an official change in status by the IRS. Examples of some qualifying events include, but are not limited to, the following:

1. Change in legal marital status – marriage, divorce, legal separation, annulment, or death of a spouse
2. Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship
3. Change in employment status of the employee's spouse or employee's dependent – switching from part- time to full-time employment status or from full-time to part-time, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage
4. Dependent satisfies or ceases to satisfy eligibility requirement – marriage of a dependent

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

A:

- If you are active, use the self-service feature from PROMT or download and complete the change form found at 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.

Q14: How do I enroll in group medical and dental insurance with Peralta?

A: Enroll online at www.benefitbridge.com/peralta

BenefitBridge

2021 ONLINE BENEFITS ENROLLMENT

Peralta Community College District Online Benefits Enrollment is easy with BenefitBridge!

Need Help?

For all questions related to your benefits, please contact your employer's benefits administrator. For BenefitBridge technical assistance ***only***, please contact BenefitBridge Customer Care at 800.814.1862; Mon – Fri, 8:00 AM – 5:00 PM, PST or email benefitbridge@keenan.com.

Here's what you can do on BenefitBridge:

- View Current Plan Year Benefits
- Compare Plan Options
- Enroll in Benefits
- Resource Center: Health Insurance Basics, Medicare, Glossary, Media Resources
- Add or Remove Dependents/Beneficiaries
- Message Center
- Update My Account Info
- Available 24/7 via the Internet

REGISTRATION AND LOGIN

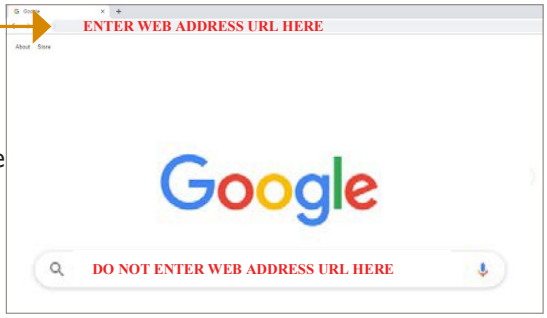
Already have login credentials?

1. Login to **BenefitBridge** at www.benefitbridge.com/peralta
2. Forgot your Username or Password? Click on **"Forgot Username/Password?"**
3. Please add or update your email address to receive an email confirmation of your enrollment approval.

Need to create login credentials?

1. In the **address bar**, type www.benefitbridge.com/peralta

(NOT IN THE BING, GOOGLE, YAHOO SEARCH ENGINE FIELD)



2. Click the **Enter** key, then follow the instructions below to registe
   - **STEP 1:** Select **"Register"** to **Create an Account**
   - **STEP 2:** Create a **Username** and **Password**
   - **STEP 3:** Select **"Continue"** to access BENEFITBRIDGE

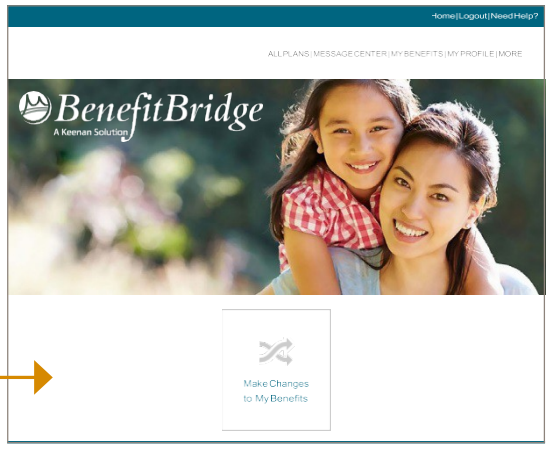
ENROLLING IN BENEFITS

Access your enrollment via the **"Make Changes to My Benefits"**

For BenefitBridge technical assistance only, please contact BenefitBridge Customer Care at

800.814.1862

Monday - Friday, 8:00 AM - 5:00 PM, PST or email benefitbridge@keenan.com.



BenefitBridge

ENVIRONMENT SUSTAINABILITY AND UPDATED PUBLICATIONS

BENEFITBRIDGE

Our partnership with BenefitBridge provides an online benefit enrollment portal for active employees. In keeping with other District sustainability initiatives, the electronic enrollment process does:

1. Allow for more timely, accurate and enrollment based on the 31-day eligibility window; and
2. Ensure the consistency of information exchanged when a qualifying event occurs (new hire, marriage, divorce, birth of child)
3. Improve the accuracy of employee and dependent data collection as transmitted to our business partners.

Retiree open enrollment and benefit changes due to a qualifying event will remain on the paper process for the current time being.

PUBLICATION UPDATES AVAILABLE ONLINE

In our on-going go-green efforts, has increased the number of documents accessible on the Peralta Benefits website (http://web.peralta.edu/benefits) and BenefitBridge resource library (www.benefitbridge.com/peralta). If you are unable to download the document, we will forward a hardcopy of the document that you request via U.S. mail within 7 – 10 days of our receipt of your request. We accept requests by phone 510.466.7229 or by email benefits@peralta.edu

Need Help?

For all questions related to your benefits, please contact the Benefits office. For BenefitBridge technical assistance *only*, please contact BenefitBridge Customer Care at 800.814.1862; Mon – Fri, 8:00 AM – 5:00 PM, PST or email benefitbridge@keenan.com.

Important Plan Notices and Documents

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, 2021
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 P L A N

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/ ACCESSIBIILITY 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 **1-877-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 **1-866-444-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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: Medicaid https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext. 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/hawki Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/

LOUISIANA – Medicaid

Website: http://www.medicaid.la.gov or http://www.ldh.la.gov/lahipp
Phone: 1-888-342-6027 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: https://www.coverva.org/hipp/ Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

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 (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.

Contact: Privacy Officer: Harizon Odembo (510) 466-7229, Address: 333 East 8th Street, Oakland, CA 94606

GENERAL NOTICE OF COBRA CONTINUATION RIGHTS

INTRODUCTION

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

The Plan Administrator is**: District Benefits Manager, Peralta Community College District, 333 East 8lh 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 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 8" 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 vent 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 CONITNUATION 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: **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.

Retiree Information

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

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

Peralta Retiree Organization (PRO) is an organization open to membership **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: www.peraltaretirees.org.

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

	Plan/Regulation		
Criteria	**COBRA Regulation (Rates will change on renewal)**	**Kaiser Permanente Senior Advantage Plan**	**Assembly Bill 528 Regulation (for Cal STRS Retirees)**
Who is eligible?	Anyone losing group dental coverage through termination of employment or retirement	A retiree or dependent who is enrollment in the traditional Kaiser and elects to join the Kaiser Senior Advantage Plan	Academicians who are retiring from STRS covered employment with PCCD
Who pays the cost?	Employee/former employee	PCCD (if retiree is enrolled on Kaiser Senior Advantage Plan)	Retiree
Duration? How long will coverage last?	As long as payments are made, generally for up to 18 months, other extensions may be possible	For duration of enrollment in the Kaiser Senior Advantage Plan with PCCD	As long as payments are made by the 10th of each current coverage month
Election window	must elect within 60 days of separation/retirement or termination	Generally within 30 days of reaching Medicare entitlement	Must elect within 60 days upon separation from service, or after exhaustion of COBRA or Cal-COBA (no late entry)
Network	Delta Dental Premier or United Health Care Dental	DeltaCare, a PMI product, limited network	Delta Dental Premier
How to elect?	Complete COBRA election form; make payments	Complete Kaiser Senior Advantage Form	Complete election form; make payments
Group number	938 (Delta Dental) / 04N6328 (UHC)	65	11504-0002
Single	UHC $31.91 / Delta: $63.24	No additional cost to retiree	$107.99
2 Party	UHC $51.04 / Delta: $107.50		$201.09
3 Party	UHC $77.77 / Delta: $164.42		$249.08
Sliding scale benefits?	No	No	Yes: Year 1: 70%; Year 2: 80%; Year 3: 90%; Year 4: 100%
Where can you obtain more information?	Combined Evidence of Coverage & Disclosure Form	DeltaCare Dental HMO Program	Carrier Summary
Website location	www.benefitbridge.com/peralta		www.deltadentalins.com

Duration of Benefits

HOW LONG DO MEDICAL BENEFITS LAST AFTER RETIREMENT?

Duration of Post-Employment District-Paid Medical Benefits are Based Upon the Employee's Most Recent Hire Date.

If hire date is:	Duration of District-Paid Benefits for Employees.	What Happens at Age 65?	Medicare Premium Reimbursement Program	District
June 30, 2004 to prior	District-paid benefits continue for the duration of the employee's (retiree's) life for both employee and eligible dependents	Employee and eligible dependent(s) apply for Medicare and retain PCCD group coverage 1. If on our Self-Funded PPO Plan, provide our Self-Funded PPO Plan card and Medicare card at each point of service 2. If on Kaiser, enroll in Kaiser Senior Advantage	The District will reimburse Medicare premium paid Medicare premiums are income indexed and vary by each participant's individual circumstance	Collective Bargaining Agreements (CBA): 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). See CBA language for dependent eligibility	No current wrap around plan in place through Peralta	Not Applicable	

Other Medical Plan Features*

If retirement date is:	Office Co-Pays	Prescription Drugs Obtained at a Retail Pharmacy	Deductible	District-Paid Vision Coverage	District-Paid Dental Insurance
June 30, 2004 or prior	Self-Funded PPO 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: United Health Care Kaiser: Available through Kaiser	Self-Funded PPO Traditional Plan: None Kaiser: Yes with Senior Advantage only
July 1, 2012 and after- We now offer three medical plan options 1. **PPO Traditional with in and out of network benefits** 2. **PPO Lite with in-network benefits only** 3. **Kaiser HMO plan**	Self-Funded PPO: Traditional Plan: $10 Lite: $10 Kaiser: $0 **For Locals 39 and 1021:** PPO Traditional: $15 PPO Lite: $15 Kaiser: $15	Self-Funded PPO: Traditional Plan: $10 -$15 Lite: $10 - $15 Kaiser: $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 PO 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.

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?

Carrier	Premiums are paid to	Address
Our Self-Funded PPO Plan	Trustmark (as our third-party administrator for our self-funded plan)	COBRA Unit #4138 PO BOX 83301 Lancaster, PA 17608-3301 866.280.4120
Kaiser	CBIZ, Inc. (formerly Pension Dynamics)	2300 Contra Costa Boulevard, Suite 400 Pleasant Hill, CA 94523 925.956.0505
United Health Care (UBC) Dental		
Delta Dental (Plans 938 & AB 528)		

4. Who is CBIZ, Inc.?

CBIZ, Inc. (formerly 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, only 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 provided you are enrolled in Kaiser District Plan.

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

No.

Medicare Enrollment FAQs

Kaiser Permanente Senior Advantage, Our Self-Funded PPO Plan and Medicare General Guidance for Medicare Coordination with Peralta Group Benefits* Frequently Asked Questions (contact the additional resources below regarding your unique circumstances)		
	If you are Active:	**If you are retired from Peralta and remain on a Peralta-Sponsored Group Plan:**
1. When should I enroll with Kaiser Senior Advantage?	Member can defer Part B of Medicare until retirement. Different rules apply for disabled and End Stage Renal Disease members.	Upon enrollment in Medicare.
2. When should dependents enroll in Kaiser Senior Advantage?	Spouses of active employees can defer Part B of Medicare until retirement. Different rules apply for disabled and End Stage Renal Disease members.	Spouses of retirees should enroll in Senior Advantage by age 65
3. Who do I contact to enroll with Kaiser Senior Advantage?	Contact Kaiser at 800.747.2189	
4. Does Kaiser assess a penalty for late Kaiser Senior Advantage enrollment?	No	No
5. What are the benefits for the retiree who enrolls in the Kaiser Senior Advantage (dental)?	Not Applicable	The Kaiser Senior Advantage plan supplements the Medicare plan and includes dental, vision and hearing aid benefits
6. When should I enroll with Medicare?	Members can defer Part B of Medicare until retirement. Different rules apply for disabled and End Stage Renal Disease members.	Three (3) months prior to your 65th birthday, or during the Medicare General Enrollment period of January 1 - March 31
7. To who are Medicare premiums paid?	Medicare premiums are normally deducted from Social Security checks or can be paid quarterly to Social Security. Please note: Active employees can defer Part B until retirement.	Medicare premiums are normally deducted from Social Security checks or can be paid quarterly to Social Security.
8. Who is eligible for reimbursement of Medicare premiums?	Not Eligible.	Retirees paying into Medicare.
9. Who do I contact to enroll with Medicare?	Contact Social Security 800.772.1213	
10. Is there a late entrant penalty with Medicare?	There is no late enrollment penalty for Part B if a member is actively covered under a group plan as a Peralta employee. Members can defer Part B of Medicare until retirement as long as the retiree applies for Medicare within three (3) months of loss of group coverage as an active employee.	If you do not enroll in Medicare upon turning age 65 you may be subject to a 10% penalty for each 12 month period not enrolled in Medicare.
11. What if I am on Our Self-Funded PPO Plan? When should I apply for Medicare B?	Defer until retirement or loss of group coverage as an active employee	Three (3) months prior to your 65th birthday, or during the Medicare General Enrollment period of January 1 - March 31
12. If I am on Our Self-Funded PPO Plan as a retiree or survivor, will I dental under Medicare?	Not Applicable	No.

*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

Social Security	800.772.1213	www.ssa.gov
Medicare	800.MEDICARE	www.medicare.gov
Kaiser Senior Advantage	800.747.2189	www.kp.org
CBIZ *(formerly Pension Dynamics*	925.956.0505	www.cbiz.com

Retirement Readiness Checklist

PRE-RETIREMENT CHECKLIST

Within 90-days of Retirement-for counseling and guidance:

- Contact California Public Employees Retirement System (CalPERS) about annuity benefits
- Contact California State Teachers Retirement System (CalSTRS) about annuity benefits
- Contact Social Security about income options
- Contact Medicare to inquire about medical options and the enrollment process

30-days prior to retirement

- Inform your department (use guidance in the Collective Bargaining Agreement)
- Complete Universal Benefit Enrollment Form in order to:
  - Confirm your insurance coverage for you and your eligible dependents as a PCCD retiree
  - Update your beneficiary on file
- After you have submitted your notice, then schedule your optional personal appointment with the Benefits Office 10 days thereafter, please bring the following items to your appointment:
  - Copy of recent paycheck
  - Copy of the submitted resignation letter
  - Completed Universal Benefit Enrollment form for continuation of medical benefits, if eligible
  - Collective Bargaining Agreement

Within 60-days (after retirement)

- Complete COBRA Election Notice to continue the following benefits beyond retirement effective date:
  - Dental coverage
  - Flexible benefit plan participation under Medical and/or dependent Care Reimbursement Account IRS Code125 Employee Assistance Program

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 dependent (new wife, child)
- Inform the district's agent of change in Medicare Premium amount

Survivor's Checklist

- Notify Benefits Office of retiree's death. Call 510.587.7838 option 5
- 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 trademarked 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.

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Peralta Community College District, Benefits office
333 East 8th Street Oakland, CA 94606
(510) 466-7229
benefits@peralta.edu
http://web.peralta.edu/benefits/