2024 – 2025 BENEFITS GUIDE

PERALTA BENEFITS

BERKELEY CITY COLLEGE | COLLEGE OF ALAMEDA | LANEY COLLEGE | MERRITT COLLEGE | DISTRICT OFFICE

CONTENTS

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 the Important Plan Information section for more details.

OPEN ENROLLMENT

Open Enrollment is a once-a-year opportunity to review your benefit choices, change plans, and add or drop dependents. After Open Enrollment ends, you cannot change your benefit elections until the next Open Enrollment, unless you experience an eligible life event.

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
- Retired, on COBRA, or a surviving spouse of a Peralta employee, then submit your change on your applicable Enrollment Forms (available in District Benefits Office and available online at www.peralta.edu/benefits
- **Special note:** New benefit eligible employees have 31 calendar days from hire date to enroll in coverage

GETTING STARTED

2024-2025 BENEFITS

October 1, 2024
through
September 30, 2025

IMPORTANT NOTE:
This guide is a summary overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents including your benefit summaries, summary of benefits and coverage (SBCs) and summary plan descriptions (SPDs). The plan documents determine how all benefits are paid.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Peralta Community College District supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are a full-time employee.

Eligible Dependents

- Your spouse (the person who you are legally married to under state law, including a same- sex spouse).
- 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.
    - Children up to age 18 of whom you have legal guardianship of.
- Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

For additional information, please refer to the plan documents for each benefit.

Who Is Not Eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.

When You Can Enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following the date of hire. You must enroll within 31 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment, the one time each year that you can make changes to your benefits for any reason. Open enrollment is generally held in May every year for an October 1st effective date.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 31 days of the date the event occurs.
3. All proper documentation is required to cover dependents(marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 31 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans.

Please review the Eligibility Documentation Checklist here as you will be required to provide proof of eligibility documentation within 31 days of eligibility.

If you do not supply the proper documentation to make changes to dependents within the 31-day period, you will not be able to add the dependent(s) until the next open enrollment period.

ENROLLING FOR BENEFITS

MID YEAR CHANGES

- You have year-round access to a summary of your benefits through BenefitBridge.
- Mid year changes should be initiated through BenefitBridge - HR may reach out for additional verification.

BenefitBridge

BenefitBridge is an online system that enables you to make all your benefit decisions in one place.

Before You Enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting Started

- LOG IN to BenefitBridge

  Username: Your last saved username and password.

  Password: Your last saved password.
- ADD your personal and dependent information.
- SELECT your benefit plans for the coming year.
- REVIEW your choices and costs before finalizing.

Need To Create Login Credentials?

- In the address bar, type in www.benefitbridge.com/peralta (Not in the Bing, Google, Yahoo search engine field)
- Click the Enter key, then follow the instructions below to register
- 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**” button.

NEED HELP?

For all questions related to your benefits, please contact Peralta Benefits Office at 510-466-7229, Mon – Fri, 8:30 AM – 5:00 PM, PST, or email benefits@peralta.edu.

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.

ENROLLING FOR BENEFITS, Cont.

NEED HELP?

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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 and BenefitBridge resource library. 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.

PERALTA BENEFITS EVERYONE, WELLNESS BEGINS WITH YOU!

CONTACT US!

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.

FOR MORE INFORMATION

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.

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

The Benefits Office now offers bi-weekly benefit orientations via zoom. For a list of times and links please visit the Benefits Office website. RSVP is required via email at benefits@peralta.edu.

www.peralta.edu/benefits is where you will find new hire orientation information. We encourage you to take full advantage of the electronic resources, self-service and self-directed resources available to you through our business partners.

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. Log on to BenefitBridge at www.benefitbridge.com/peralta to view your information and resources.

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 – 403 (b)	X	X	X	X
Post-tax Roth 403 (b)	X	X	X	X
Tax Deferred – 457 (b)	X	X	X	X
Post-tax Roth 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.**
**** If eligible for medical coverage.**

- 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 www.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

OUR PLANS

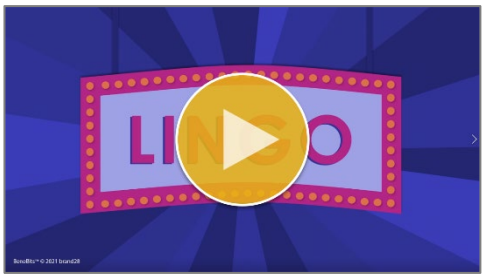
Kaiser HMO - $10 Copay

Kaiser HMO - $15 Copay

Anthem PPO – 100-A $10; Rx 5-20

Anthem PPO 2 – 80-E $20; Rx 5-20

All About Medical Plans



Play the Health Lingo Game!

We offer a variety of medical plan through SISC, depending on your bargaining group.

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you frequently visit the doctor or urgent care? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

WHICH PLAN IS RIGHT FOR YOU?

Consider an HMO (Health Maintenance Organization) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network
- You have convenient access to Kaiser facilities

Plan To Consider

- Kaiser Traditional HMO

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers

Plans To Consider

- Anthem PPO – 100-A $10; Rx 5-20
- Anthem PPO 2 – 80-E $20; Rx 5-20

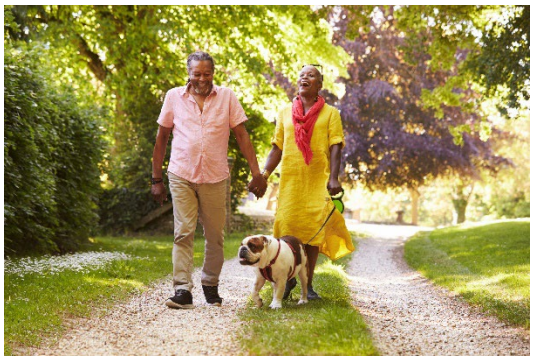
Kaiser Medical HMO (SISC) Plans (Active Employees)

You always pay the deductible and copayment ($). 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.

	Kaiser HMO - $10 Copay (Managers & PFTs)	Kaiser HMO - $15 Copay (Local 39, 1021 & Confidential)
	In-Network Only	In-Network Only
Calendar Year Deductible[1] Individual Family Embedded/Aggregate[2]	None Embedded	None Embedded
Calendar Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[3]	$1,500 $3,000 Embedded	$1,500 $3,000 Embedded
Office Visit Primary Care Specialist	$10 copay $10 copay	$15 copay $15 copay
Eyeglasses or Contacts Once every 24 months	$150 allowance	$150 allowance
Preventive Services	No Charge	No Charge
Chiropractic	Not Covered	Not Covered
Lab and X-ray	No Charge	No Charge
Urgent Care	$10 copay	$15 copay
Emergency Room (waived if admitted)	$100 copay	$100 copay
Inpatient Hospitalization	No Charge	No Charge
Outpatient Surgery	$10 per procedure	$15 per procedure
PRESCRIPTION DRUGS		
Calendar Year Deductible	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Retail- 30 Day Supply Generic Brand Specialty	$10 /prescription $10 / prescription $10 / prescription	$5 /prescription $20 / prescription $20 / prescription
Mail Order- 100 Day Supply Generic Brand Specialty	$10 /prescription $10 / prescription $10 / prescription	$10 /prescription $40 / prescription Not covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year basis.
[2] An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum. All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

RESOURCES FOR KAISER MEMBERS



FINDING A KAISER PROVIDER

To find a Kaiser Permanente provider near you, please visit www.kp.org or call (800) 464-4000.

MY HEALTH MANAGER

Stay engaged with your health and simplify your busy life by using the Kaiser Website or download the Kaiser Permanente app from the App Store℠ or Google Play®.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (833) 574-2273.

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Kaiser's travel website will explain what to do if you need emergency or urgent care during your trip.

Target Retail Clinics

Target Clinics offer care provided by Kaiser Permanente for more than 85 different services, including treatments for common health conditions and minor injuries. The clinics are open 7 days a week for appointments and walk-in care. Find a clinic near you using kptargetclinic.org.

Active&Fit

The Active&Fit Direct program allows you to choose from 9,000+ participating fitness centers and YMCAs nationwide for $28 a month (plus a $25 enrollment fee and applicable taxes). To enroll, visit kp.org/choosehealthy, select your area, click the "Choose Healthy" link, and click "Learn More".

myStrength

The myStrength app is designed to help navigate life's challenges, make positive changes, and support your overall well-being. The app can help you set goals and work towards them in the ways that work best for you. You can access myStrength at kp.org/selfcareapps and choose the mental health and wellness areas you want to focus on.

Ginger App

Use the Ginger app to text one-on-one with an emotional support coach anytime, anywhere. Through the app you have access to 24/7 text-based emotional support coaching and self-care resources recommended for your needs. Download Ginger from the App Store℠ or Google Play®.

Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps .

Anthem PPO SISC Plans

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.

	Anthem PPO 1 – 100-A $10; Rx 5-20		Anthem PPO 2 – 80-E $20; Rx 5-20	
	In-Network	Out-of--Network	In-Network	Out-of--Network
Calendar Year Deductible[1] Individual Family Embedded/Aggregate[2]	None None N/A		$300 $600 Embedded	
Calendar Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[3]	$1,000 $3,000 Embedded	No limit	$1,000 $3,000 Embedded	No limit
Office Visit Primary Care Specialist	$0 copay per visit for visits 1-3, then $10 copay per additional visit $10 copay per visit	Member pays difference between max allowed and actual charges	$0 copay per visit for visits 1-3, then $20 copay per additional visit $20 copay per visit	Member pays difference between max allowed and actual charges
LiveHealth Online Primary Care Specialist	No charge $10 copay per visit		No charge $20 copay per visit	
Preventive Services	No charge	Not covered	No charge	Not covered
Chiropractic	No charge	Not covered	20% after deductible	Not covered
Lab and X-ray CT, MRI, PET scans Other lab and x-ray tests	No charge No charge	Member pays all billed amounts exceeding $800 per test[4] Not covered	20% after deductible 20% after deductible	Member pays all billed amounts exceeding $800 per test[4] Not covered
Urgent Care	$10 copay	Member pays difference between max allowed and actual charges	$20 copay	Member pays difference between max allowed and actual charges
Emergency Room	$100 copay (waived if admitted)		$100 copay + 20% after deductible (waived if admitted)	
Inpatient Hospitalization	No charge	All billed amounts exceeding $600 per day[4]	20% after deductible	All billed amounts exceeding $600 per day[4]
Outpatient Hospitalization	No charge	All billed amounts exceeding $350 per day[4]	20% after deductible	All billed amounts exceeding $350 per day[4]
PRESCRIPTION DRUGS[5]				
Calendar Year Deductible	None		None	
Out-of-Pocket Maximum (Individual/Family)	$1,500 / $2,500		$1,500 / $2,500	
Retail - 30 Day Supply (Network Pharmacy) Generic Brand	$5 copay $20 copay		$5 copay $20 copay	
Mail Order - 90 Day Supply (Costco) Generic Brand	$0 copay $50 copay		$0 copay $50 copay	

[1] Deductibles and out-of-pocket maximums accumulate on a calendar year basis.
[2] An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3] An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum. All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[4] When using non-network providers, the plan will pay the lesser of the benefit maximum or the maximum allowed amount. If the maximum allowed amount is less than the listed benefit maximum, the plan will not exceed the maximum allowed amount.
[5] Prescriptions are available through Navitus and not Anthem. Log into the member home page at navitus.com to find pharmacies that are in your plan, or call (866) 333-2757. See page 18 for details.

RESOURCES FOR ANTHEM MEMBERS

FINDING AN ANTHEM PROVIDER

To find a provider in the Anthem PPO network, please visit www.anthem.com/ca/sisc.

SYDNEY MOBILE APP

Use Sydney™ Health to keep track of your health and benefits- all in one place. Access your plan details, Member Services, virtual care, and wellness resources. You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

Active&Fit

The Active&Fit Direct program allows you to choose from 9,000+ participating fitness center and YMCAs nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes). To enroll, visit Special Offers by logging into www.anthem.com/ca/sisc and clicking on Discounts.

Building Healthy Families

Building Healthy Families offers personalized, digital support through the Sydney℠ Health mobile app or on anthem.com/ca. This all-in-one program, at no extra cost to you, can help your family grow strong whether you're trying to conceive, expecting a child, or in the thick of raising young children.

Payforward

Anthem members can earn up to 15% cash back instantly at more than 12,000 in-store and online retailers. This includes retailers like Home Depot, The Gap, Target and more. It's free to join and only takes a few simple steps to get started. Register at anthem.payforward.com.

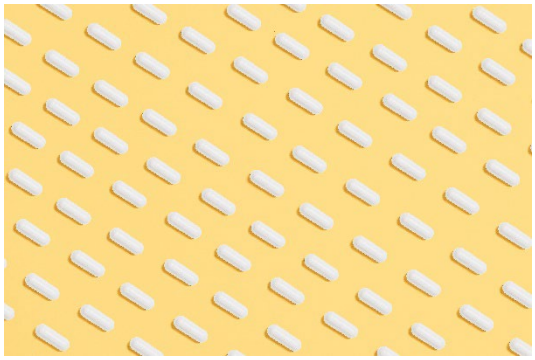
24/7 Nurse Line

24/7 NurseLine serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care.

Hip, Knee, and Spine Surgeries: Blue Distinction+ Requirement

In order to be covered by the Preferred Provider Organization (PPO) plan, hip and knee replacements and certain inpatient spine surgeries must be performed at an Anthem Blue Cross Blue Distinction+ center. BD+ Centers meet affordability criteria and deliver better results — including fewer complications and readmissions — than other hospitals. For a specific list of hip, knee, and spine procedures that are part of the program, please call the Customer Service number on the back of your ID card. To find BD+ hospital, go to anthem.com/ca/sisc/find-care and scroll down to "Blue Distinction Centers and Centers of Medical Excellence."

PRESCRIPTION DRUGS – NAVITUS



NAVITUS APP

You can also use the Navitus app to search for providers. Download from the App Store or Google Play®.

FORMULARY

You can also find a list of formulary and preventive medications on the Navitus Website.

Understanding Your Pharmacy Benefits

Members who take stabilized doses of covered long-term maintenance medications — like those used to treat an ongoing condition such as high blood pressure or high cholesterol — can save money by ordering them through Navitus' mail service partner, Costco Pharmacy, instead of using a retail pharmacy.

With the Costco Home Delivery Pharmacy

- You get up to a 90-day supply delivered directly to you — with free standard shipping.
- You can easily order refills online, over the phone or by mail.
- Multiple safety and advanced quality checks are in place to make sure you get the right medication.

Please contact Costco Home Delivery Pharmacy at pharmacy.costco.com. You may also call 1-800-607-6861 for home delivery forms and instructions. Please note that some pharmacies, such as Walgreens®, may not be in your plan. Log into the member home page at navitus.com to find pharmacies that are in your plan, or call (866) 333-2757.

REIMBURSEMENT PROGRAMS

Kaiser and Anthem Reimbursement Programs

The Peralta Benefits Office is pleased to announce enhancements to the active employee medical and prescription reimbursement program. Please refer to the attached schedule of benefits for eligible reimbursements.

1. Starting May 1, 2024 you can to submit eligible expenses to Navia using the updated reimbursement request form.
2. Refer to the new schedule of benefits for eligible reimbursements.
3. What is needed for Navia to process my claim?
    - Complete all requested information on the reimbursement form, sign, date & return to Navia not the District Benefits Office.
    - Attach an itemized Explanation of Benefits (EOB) or receipt from the Insurance Carrier/Provider to support the requested reimbursements.
    - EOB/RECEIPT MUST INCLUDE: Date of service, name of claimant, description of expense, cost of expense and the amount patient responsible for clearly listed for approval. Please keep your primary EOB or receipts for your records and submit your claim to Navia for reimbursement. Once Navia receives your claim, they will consider your claim for reimbursement and issue payment directly to you via check.
    - Expense must be submitted within one year of the date of service.
    - The claim must be considered by the Primary Insurance Carrier before Navia can process and consider the claim.
4. How can I submit my claims to Navia?
    - There are several methods of submission for claims available.
      Need Assistance? Call 559-256-1320 or Toll-Free 866-777-1320 or email us at sps@naviabenefits.com
      Fax – 559.475.5780
      Mail – Navia Benefits Solutions, P.O. Box 5809
      Fresno, CA. 93755
5. Who can I reach out to if I have questions about my reimbursement request?
    - Navia's Scheduled Plan Services (SPS) team of experts are committed to addressing all your inquiries. Please see the last page of this packet to connect with Navia's SPS team.

REIMBURSEMENT PROGRAMS (Continued)

6. Who is eligible for reimbursement?

   - Active employees and their enrolled dependents.
   - All dependent requests will be reimbursed to the employee.

7. Can I claim an expense on my HRA account if I have been reimbursed from me FSA account?

   - If reimbursed by Navia for an eligible expense using your HRA account, you cannot claim that same expense using funds from your FSA HealthCare account.

8. If I have both HRA and FSA accounts with Navia are the claim forms, contact information and web portals the same?

   - **Distinct procedures and addresses are required for submitting reimbursement requests for each program. They are completely different.**

9. What is the turnaround time for claims processing?

   - Typical turnaround time for claims processing is 5 business days from the date Navia receives the claim. Holidays or delays in receiving the appropriate information may impact the standard turnaround time. You can call or email Navia to check the status of your claim (see contact below). **This is an enhancement to the previous commitment of processing claims twice each year.**

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- www.naviabenefits.com
- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

Open Enrollment For This Plan Period for FSA is from May 6th, 2024 through June 7th , 2024.

The Plan is Effective from October 1st through September 30th

Set Aside Healthcare Dollars For The Coming Year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through Navia and must be elected via BenefitBridge.

How Navia's FSA Works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,200, the 2024 annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 10/01/2024 and 09/30/2025 (2 ½ month "grace period" after the end of the plan year to incur claims) and claims must be submitted for reimbursement no later than 12/31/2025. If you don't spend all the money in your account, you forfeit the leftover balance.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

FSA TAX SAVINGS EXAMPLE (SINGLE FILERS)

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,850 FSA Contribution

$684 24% Federal income tax	**$219** 7.65% FICA tax	**$903** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Open Enrollment For This Plan Period for FSA is from May 6th, 2024 through June 7th , 2024.

The Plan is Effective from October 1st through September 30th

Dependent Care FSA—up To $5,000 Per Year Tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by Navia and must be elected via BenefitBridge.

Here's How Navia's Dependent Care FSA Works

You set aside money from your paycheck, before taxes, to pay for work-related daycare expenses. Eligible expenses include not only childcare, but also before and afterschool care programs, preschool, and summer day camp for children under age 13. The account can also be used for daycare for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $2,500 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Expenses must be incurred between 10/01/2024 and 09/30/2025 (2 ½ month "grace period" after the end of the plan year to incur claims) and claims must be submitted for reimbursement no later than 12/31/2025. If you don't spend all the money in your account, you forfeit the leftover balance.

Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

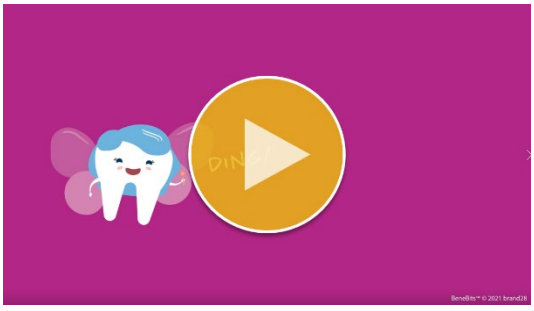
DENTAL

OUR PLANS

United Health Care DHMO

Delta Dental DPPO

Click to play video



We offer 2 dental plan(s) through United Healthcare and Delta Dental.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

Dental Plans

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.

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	UnitedHealthcare DHMO	Delta Dental DPPO	
	In-Network	In-Network	Premier Network & Out-of-Network[1]
Annual Deductible	None	None	None
Annual Plan Maximum	Unlimited	$1,600	$1,500
Waiting Period	None	None	None
Diagnostic & Preventive	No Charge (see contract for fee schedule)	No Charge[2]	No Charge[2]
Basic Services Fillings Root Canals Periodontics	No Charge (see contract for fee schedule)	No Charge[2]	No Charge[2]
Major Services	No Charge (see contract for fee schedule)	No Charge[2]	No Charge[2]
Orthodontia Adults Children (up to age 26)	Copay varies (see contract for fee schedule)	50% Coinsurance	50% Coinsurance
Ortho Lifetime Max	Unlimited	$1,000	$1,000 (combined with in-network)

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

Find a Provider

- UHC DHMO - visit www.myuhcdental.com or call (800) 999-3367.
- Delta Dental - visit www.deltadentalins.com or call (800) 765-6003.

VISION

OUR PLANS

UHC Union Vision Plan (bundled with Anthem medical)

Kaiser HMO Vision Plan (bundled with Kaiser medical)

VSP Vision Choice Plan (voluntary)

Click to play video

We offer 3 vision plan(s) through UHC, Kaiser, and VSP.

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

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

** In lieu of glasses.

Voluntary Vision

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

	VSP Vision Choice Plan Additional cost to the employee	
	In-Network	**Out-of-Network**
Exams Benefit Frequency	$10 copay Once 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 for 100% basic lens Plan pays for 100% basic lens Once every 12 months	 Up to $30 Up to $50 Up to $65 In-network limitations apply
Frames Benefit Frequency	 Up to $130 Once every 12 months	 Up to $70 In-network limitations apply
Contacts (Elective) Benefit Frequency	 Up to $130 Once every 12 months	 Up to $105 Once every 12 months

Coverage Tier	Monthly Premium
Employee Only	$10.84
Employee + 1 Dependent	$16.84
Employee + Family	$26.71

What you need to know about this plan

Features:	See any provider, but you'll pay more out of network
What other services are covered?	The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.
Eyeglasses are expensive. Will I still be able to afford them, even with insurance?	Look for moderately priced frames and remember that your benefit is higher in-network.
Where can I get more details?	Use the VSP website or app.

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

DISTRICT-PROVIDED LIFE AND AD&D INSURANCE

A NOTE ABOUT TAXES

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Voya Financial, and premiums are paid in full by Peralta Community College District.

Active Employee Basic Life and AD&D Amount	**Employee:** 1.5 times your basic annual earnings up to $100,000. The amount is rounded to the next higher $1,000. **Spouse/Domestic Partner:** $1,000 **Children after birth to 6 months**: $100 **Children 6 months but less than age 26:** $500

Note: 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)

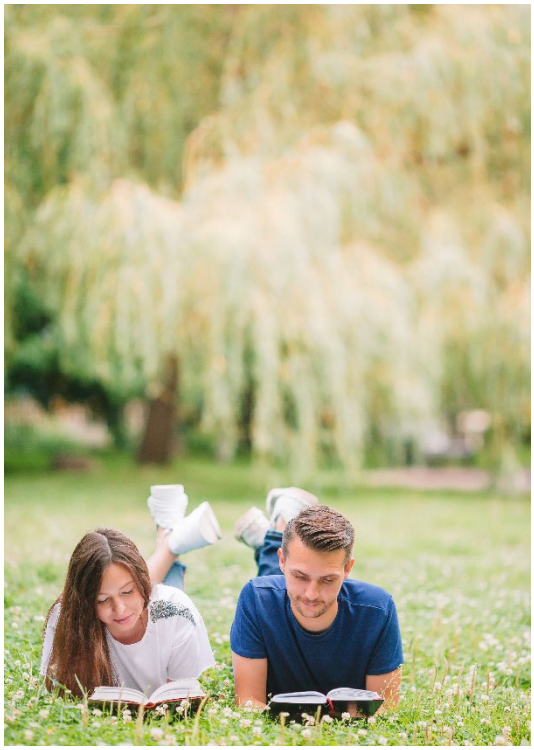
Active Board of Trustee Employee Basic Life Amount	**Employee:** $100,000. **Spouse/Domestic Partner:** $1,000 **Children after birth to 6 months**:$100 **Children 6 months but less than age 26:** $500

Note: Coverage does not reduce or terminate due to age

Active Chancellor Basic Life and AD&D Amount	**Employee:** 1.5 times your basic annual earnings up to $600,000. The amount is rounded to the next higher $1,000. **Spouse/Domestic Partner:** $1,000 **Children after birth to 6 months**:$100 **Children 6 months but less than age 26:** $500

Note: 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 INSURANCE



BENEFICIARY REMINDER FOR BASIC AND VOLUNTARY LIFE AND AD&D:

Make sure that you have named a beneficiary for your life insurance benefit. If full-time, please update your beneficiary information on www.benefitbridge.com/Peralta.

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Voya Financial and available for your spouse and child(ren).

Voluntary Life and AD&D

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 Life Amount	**6 months and older**: Increments of $2,000 up to $10,000; **Under 6 months**: $500

Application at annual enrollment for an increase to existing supplemental coverage by one plan increment, when new coverage combined with existing supplemental coverage does not exceed Limit without Proof. Please refer to the, "YOUR GROUP SUPPLEMENTAL LIFE INSURANCE PLAN" document.

*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 plan increment that exceeds the limit without proof at Open Enrollment. See Benefit Office Support Services for more information

Evidence of Insurability (EOI)

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.

LONG-TERM DISABILITY INSURANCE (LTD)

3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for long-term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Peralta Community College District pays for the cost of this coverage. Coverage is provided by Voya Financial.

VOYA FINANCIAL LTD Plan

Monthly benefit amount	60% up to a maximum of $5,000
Benefits begin	**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

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

LEGAL SERVICES

IDENTITY THEFT PROTECTION

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

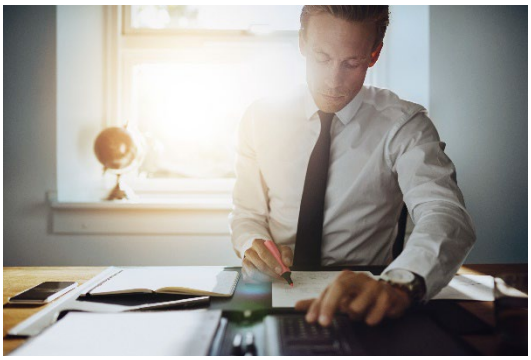
Peralta Community College District offers plans to help:

- secure your identity
- manage legal issues

You pay the entire cost for these plans, but rates may be more affordable than individual coverage.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

PLANS TO KEEP YOU AND YOUR FAMILY SECURE



AFFORDABLE PROTECTION

$21.95 to $50.90 /monthly.

For more information, visit:
www.legalshield.com/info/pccd

Identity Theft Protection

Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly premium, identity theft protection from LegalShield helps protect your personal information through proactive monitoring, identity restoration, and resolution. You can enroll in this program during open enrollment.

Legal Program

Do you have an attorney on retainer? Most people don't, so our legal program offers you access to legal advice and even representation for an affordable monthly premium. Whether you need assistance reviewing a rental agreement, fighting a traffic ticket, creating a will, buying a house or navigating an IRS audit, legal coverage from LegalShield offers reputable attorney assistance for you and your family. You can enroll in this program during open enrollment.

FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

403(b) Plan

457(b) Plan

Is it time for a “financial wellness” checkup?

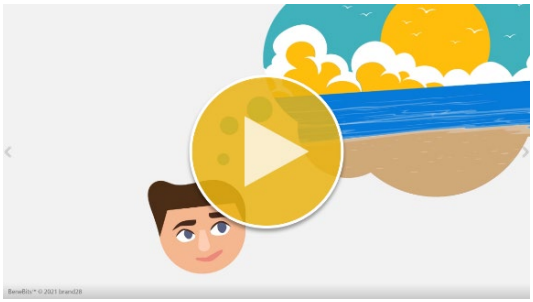
Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. Worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future.

SAVE NOW, ENJOY LATER

Click to play video



ELIGIBILITY

Most employees are eligible to participate in the 403(b) and 457(b) plans immediately upon employment, however, private contractors, appointed/elected trustees, school board members, and student workers are not eligible to participate in these Plans. Eligible employees may make voluntary elective deferrals to both the 403(b) and 457(b) plans, and participants are fully vested in their contributions and earnings at all times.

INVESTMENT PROVIDER INFORMATION

A current list of authorized 403(b) and 457(b) Investment Providers and current employer forms are available on third party administrator website https://www.tsacg.com.

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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 or post tax(Roth) 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

403(b) Plan And 457(b) Deferred Compensation Plan

The 403(b) and 457(b) Plans are valuable retirement savings options. This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) and 457(b) Plans offered.

Plan administration services for the 403(b) and 457(b) plans are provided by U.S. OMNI & TSACG Compliance Services. Visit the U.S. OMNI & TSACG Compliance Services website (https://www.tsacg.com) for information about enrollment in the plan, investment product providers available, distributions, exchanges or transfers, 403(b) and/or 457(b) loans, and rollovers.

Plan Administrator Contact Information

Transactions
P.O. Box 4037
Fort Walton Beach, FL 32549
Toll-free: 1-888-796-3786
https://www.tsacg.com

For overnight deliveries
73 Eglin Parkway NE, Suite 202
Fort Walton Beach, FL 32548
Toll-free: 1-888-796-3786
https://www.tsacg.com

403(b) PLAN AND 457(b) DEFERRED COMPENSATION PLAN

AGE-BASED ADDITIONAL AMOUNT

Participants who are age 50 or older any time during the year qualify to make an additional contribution of up to $7,500 to the 403(b) and/or 457(b) accounts.

EMPLOYEE INFORMATION STATEMENT

Participants in defined contribution plans are responsible for determining which, if any, investment vehicles best serve their retirement objectives. The 403(b) and 457(b) plan assets are invested solely in accordance with the participant's instructions. The participant should periodically review whether his/her objectives are being met, and if the objectives have changed, the participant should make the appropriate changes. Careful planning with a tax advisor or financial planner may help to ensure that the supplemental retirement savings plan meets the participant's objectives.

EMPLOYEE CONTRIBUTIONS

Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) and/or 457(b) account(s) up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. You also have the option to contribute to a ROTH 403b and/or 457b account(s) up to their maximum annual contribution amount on a post tax basis Contributions to the participant's 403(b) or 457(b) accounts are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred if select pre-tax plan until the participant withdraws their funds. Employees may also select a Roth plan which is post tax or select both a pre-tax (IRA) and post tax (Roth) plans

The Internal Revenue Service regulations limit the amount participants may contribute annually to tax-advantaged retirement plans and imposes substantial penalties for violating contribution limits. U.S. OMNI & TSACG Compliance Services monitors 403(b) and 457(b) plan contributions and notifies the employer in the event of an excess contribution.

The basic contribution limit for 2024 is $23,000 for both IRA and Roth plans.

ENROLLMENT

Employees who wish to enroll in the 403(b) and/or 457(b) plan must first select the provider and investment product best suited for their account. Upon establishment of the account with the selected provider, a "Salary Reduction Agreement" (SRA) form and/or a deferred compensation enrollment form and any disclosure forms must be completed and submitted to the employer. These forms authorize the employer to withhold 403(b) and/or 457(b) contributions from the employee's pay and send those funds to the Investment Provider on their behalf. An SRA form and/or a deferred compensation enrollment form must be completed to start, stop or modify contributions to 403(b) and/or 457(b) accounts. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

Please note: The total annual amount of a participant's contributions must not exceed the Maximum Allowable Contribution (MAC) calculation. For convenience, a MAC calculator is available at https://www.tsacg.com.

403(b) PLAN AND 457(b) DEFERRED COMPENSATION PLAN (Continued)

PLAN DISTRIBUTION TRANSACTIONS

Distribution transactions may include any of the following depending on the employer's Plan Document: loans, transfers, rollovers, exchanges, hardships, unforeseen financial emergency withdrawals or distributions. Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator for processing.

PLAN-TO-PLAN TRANSFERS

A plan-to-plan transfer is defined as the movement of a 403(b) and/or 457(b) account from a previous plan sponsor's plan and retaining the same account with the authorized investment provider under the new plan sponsor's plan.

ROLLOVERS

Participants may move funds from one qualified plan account, i.e. 403(b) account, 401(k) account or an IRA or ROTH PLAN, to another qualified plan account at age 59½ or when separated from service. Rollovers do not create a taxable event.

HARDSHIP WITHDRAWALS

Participants may be able to take a hardship withdrawal in the event of an immediate and heavy financial need. To be eligible for a hardship withdrawal according to IRS Safe Harbor regulations, you must verify and provide evidence that the distribution is being taken for specific reasons. These eligibility requirements to receive a Hardship withdrawal are provided on the Hardship Withdrawal Disclosure form at https://www.tsacg.com.

UNFORESEEN FINANCIAL EMERGENCY WITHDRAWAL

You may be able to take a withdrawal from your 457(b) account in the event of an unforeseen financial emergency. An unforeseeable emergency is defined as a severe financial hardship of the participant or beneficiary. The eligibility requirements to receive a Unforeseen Financial Emergency Withdrawal are provided on the Unforeseen Financial Emergency Withdrawal Disclosure form at https://www.tsacg.com.

403(b) PLAN AND 457(b) DEFERRED COMPENSATION PLAN (Continued)

DISTRIBUTIONS

Retirement plan distributions are restricted by IRS regulations. A participant may not take a distribution of 403(b) plan accumulations without penalty unless they have attained age 59½ or separated from service in the year in which they turn 55 or older. Generally, a distribution cannot be made from a 457(b) account until you have a severance from employment or reach age 72. In most cases, any withdrawals made from a 403(b) or 457(b) account are taxable in full as ordinary income if a pre-tax IRA plan. Roth plans are not taxable since they are post tax.

EXCHANGES

Within each plan, participants may exchange account accumulations from one investment provider to another investment provider that is authorized under the same plan; however, there may be limitations affecting exchanges, and participants should be aware of any charges or penalties that may exist in individual investment contracts prior to exchange. Exchanges can only be made from one 457(b) plan to another 457(b) plan, or from one 403(b) plan to another 403(b) plan.

403(b) and 457(b) PLAN LOANS

Participants may be eligible to borrow their 403(b) and/or 457(b) plan accumulations depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer plan. If loans are available, they are generally granted for a term of five years or less (general-purpose loans). Loans taken to purchase a principal residence can extend the term beyond five years depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider. Prior to taking a loan, participants should consult a tax advisor.

Comparison of Governmental and 457(b)

Features	Governmental 457 Plan	403(b) Plan
Contribution Limits Year 2024	$23,000 basic maximum contribution limit 457 Limits not coordinated with 403(b) plan	$23,000 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 $7,500 annual limit - not permitted if special catch-up option used	Total of $7,500 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 • Unforeseeable emergency	Funds cannot be distributed until: • Age 59 ½ • Age 55 and/or severance from employment • Disability • Death; or • Financial hardship
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, or Roth, 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, or Roth, 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

WELLBEING & BALANCE

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health, and family issues

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

EMPLOYEE ASSISTANCE PROGRAM (EAP) – SISC MEMBERS

CONTACT THE EAP

Phone
800-999-7222

Website
www.ANTHEMEAP.COM

Company Name: SISC

Help For You And Your Household Members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Anthem can help you handle a wide variety of personal issues, such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free, and available to any member of your immediate household.

No Cost EAP Resources **For Members Enrolled in a SISC Medical Plan**

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 6 visits per issue
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

TALKSPACE – SISC MEMBERS

CONTACT TALKSPACE

Website:
www.talkspace.com/associatecare
Organization: SISC
Phone: 800-999-7222

Virtual Behavioral Health Services For Members Enrolled in a SISC Medical Plan

Now, more than ever, the world needs easy access to mental health care. Peralta Community College District is excited to offer Talkspace –a clinician-led virtual service designed to improve behavioral health and emotional well-being. Talkspace is a Peralta Community College District funded benefit, now available to all employees and their dependents age 13 and older.

How It Works

Talkspace matches you with a dedicated, licensed clinician when, where, and how it's most comfortable for you. 70% of Talkspace members see clinically significant symptom improvement in less than 12 weeks.

- Create a private, personalized support plan with your provider of choice
- Unlimited messaging by text, voice, video, or photo
- Every Talkspace member has a secure, private "room" to communicate with their therapist and can send messages in the room 24/7
- Book two 30-minute live video sessions per month via web or mobile app using the Live Scheduler tool
- Access to self-guided exercises such as meditation and journaling, whether or not you engage with a therapist

Lasting Relationship Counseling App

When people have strong relationships, they can show up in all areas of life with more focus and less stress.

- Can be used alone or combined with Talkspace therapy
- Improve relationship satisfaction featuring topical sessions, discussion guides, live workshops and more!
- Pairs sign up individually and connect accounts within the app
- Sessions are completed independently, allowing each person to reflect and express feelings on a number of topics, including conflict and communication
- Sessions are compared, allowing each person to safely learn and comment about the other's thoughts, feelings, and needs
- Popular topics of discussion include Relationship Foundations, Emotional Connection, Parenting Together, and Family Culture

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your benefit contributions
- Contact information for our benefit carriers and vendors
- Retiree information
- FAQ
- A summary of the health plan notices you are entitled to receive annually, and where to find them

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Peralta Community College District if your domestic partner is your tax dependent.

2024-2025 MONTHLY CONTRIBUTION RATE MATRIX

- For Active, Benefit-Eligible Employees
- Rates are subject to the outcome of union negotiations
- Complete Table on Benefits Webpage: www.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**	**Anthem PPO (Grndf)**	**Anthem PPO**	**Anthem PPO 2**	**Kaiser HMO**	**Anthem PPO (Grndf)**	**Anthem PPO**	**Anthem PPO 2**
Employee Pays	$0.00	$15.00	$305.20	$252.60	$0.00	$15.00	$105.29	$87.15
Peralta Pays	$977.00	$1,511.00	$1,220.80	$1,010.40	$953.00	$1,511.00	$1,420.71	$1,175.85
Total Cost	**$977.00**	**$1,526.00**	**$1,526.00**	**$1,263.00**	**$953.00**	**$1,526.00**	**$1,526.00**	**$1,263.00**
Two-Party Coverage	**Kaiser HMO**	**Anthem PPO (Grndf)**	**Anthem PPO**	**Anthem PPO 2**	**Kaiser HMO**	**Anthem PPO (Grndf)**	**Anthem PPO**	**Anthem PPO 2**
Employee Pays	$0.00	$30.00	$600.80	$495.60	$0.00	$30.00	$225.30	$185.85
Peralta Pays	$1,914.00	$2,974.00	$2,403.20	$1,982.40	$1,868.00	$2,974.00	$2,778.70	$2,292.15
Total Cost	**$1,914.00**	**$3,004.00**	**$3,004.00**	**$2,478.00**	**$1,868.00**	**$3,004.00**	**$3,004.00**	**$2,478.00**
Family Coverage	**Kaiser HMO**	**Anthem PPO (Grndf)**	**Anthem PPO**	**Anthem PPO 2**	**Kaiser HMO**	**Anthem PPO (Grndf)**	**Anthem PPO**	**Anthem PPO 2**
Employee Pays	$0.00	$45.00	$847.60	$697.80	$0.00	$45.00	$317.85	$261.66
Peralta Pays	$2,695.00	$4,193.00	$3,390.40	$2,791.20	$2,631.00	$4,193.00	$3,920.15	$3,227.34
Total Cost	**$2,695.00**	**$4,238.00**	**$4,238.00**	**$3,489.00**	**$2,631.00**	**$4,238.00**	**$4,238.00**	**$3,489.00**

**** Anthem PPO (Grndf) rates are grandfathered from former PPO Lite rates. 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, Confidential**	**Managers**	**PFT**	**Local 39, 1021, Confidential**
Employee Pre-tax*	$27.02	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	$58.93	$58.93	$58.93	$31.91	$31.91	$31.91
Two-Party Coverage	**Managers**	**PFT**	**Local 39, 1021, Confidential**	**Managers**	**PFT**	**Local 39, 1021, Confidential**
Employee Pre-tax*	$49.14	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	$100.18	$100.18	$100.18	$51.04	$51.04	$51.04
Family Coverage	**Managers**	**PFT**	**Local 39, 1021, Confidential**	**Managers**	**PFT**	**Local 39, 1021, Confidential**
Employee Pre-tax*	$75.44	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	$153.21	$153.21	$153.21	$77.77	$77.77	$77.77

*Designation as it appears on the Peralta pay advices.

2024-2025 PLAN RATE MATRIX

- For Post 2012 Retirees
- Complete Table on Benefits Webpage: www.peralta.edu/benefits

Retiree Without Medicare Coordination*

	Medical Coverage (for all employees except Local 39, 1021 and Confidential)		Medical Coverage (for Local 39, 1021 and Confidential)	
Single Party	**Anthem PPO**	**Anthem PPO 2**	**Anthem PPO**	**Anthem PPO 2**
Retiree Pays	$305.20	$252.60	$105.29	$87.15
Two-Party	**Anthem PPO**	**Anthem PPO 2**	**Anthem PPO**	**Anthem PPO 2**
Retiree Pays	$600.80	$495.60	$225.30	$185.85
Family	**Anthem PPO**	**Anthem PPO 2**	**Anthem PPO**	**Anthem PPO 2**
Retiree Pays	$847.60	$697.80	$317.85	$261.68

***Employees who were enrolled in PPO Lite plan as of December 31, 2022, and chose to enroll in the PPO Plan effective January 1, 2023, were grandfathered. Currently there is no premium for Anthem PPO (Grandfathered employees) or Kaiser HMO. Rates subject to change upon annual renewal or for external compliance.**

*Designation as it appears on the Peralta pay advices.

PLAN CONTACTS

Insurance & Carrier Contact Information			
Carrier	Website	Group Number	Phone Number
SISC – Kaiser HMO	www.kp.com/sisc	606394	800-464-4000
SISC – Anthem PPO	www.anthem.com/ca/sisc	40965	See ID Card
SISC – Navitus Health Solutions Rx	www.Navitus.com	ANT	844-268-9789
Delta Dental PPO	www.deltadentalins.com	938	800-765-6003
United Healthcare Dental DHMO	www.myuhcdental.com	729309	800-999-3367
United Healthcare Vision	http://www.myuhcvision.com/	754439	800-638-3120
Vision Service Plan	www.vsp.com	N/A	800.638.3120
Anthem Employee Assistance Program (via SISC)	www.anthemEAP.com	N/A	800-999-7222
Talkspace	www.talkspace.com/associatecare	N/A	800-999-7222
Voya Basic & Supplemental Life/AD&D and LTD Plans	www.voya.com	67094-4	800-955-7736
Legal Shield	www.legalshield.com/info/pccd	N/A	866-288-5229
Navia Benefits (FSA/Commuter)	www.naviabenefits.com		800-669-3539
Navia Benefits (Retiree Reimbursement HRA/Medical & Prescription Reimbursement Program)	www.asibenefits.vbagateway.com	YGT	559-256-1320
Navia Benefits (Medicare A, B, and D Premium Reimbursement Program)	www.naviabenefits.com	YGT	866-897-1996
Navia Benefits (COBRA/Retiree Direct Bill)	www.naviabenefits.com	YGT	877-920-9675
Navia Benefits (Active Employee Reimbursements)	www.naviabenefits.com	YGT	559-256-1320
Retiree First (Anthem MAPD & United American Plans)	www.retireefirst.com/PeraltaCCD/	N/A	855-460-7312
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			
PERS	www.calpers.ca.gov	N/A	888-225-7377
STRS	www.calstrs.com	N/A	800-228-5453
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

RETIREE INFORMATION

Retirees who are eligible for PERS or STRS retirement benefits upon separation from 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 provide assistance and representation to and for retirees in matters relating to retirement, and to sponsor activities for the general welfare of its members. PRO distributes a periodic newsletter which keeps its membership informed on a variety of District events and activities. Visit the PRO website for more information: www.peraltaretirees.org.

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

	Plan/Regulation		
Criteria	COBRA Regulation (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: $59.75	No additional cost to retiree	$107.99
2 Party	UHC $51.04 / Delta: $101.57		$201.09
3 Party	UHC $77.77 / Delta: $155.35		$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

FREQUENTLY ASKED QUESTIONS

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

A: Please see page 5 for "who is eligible" and page 7 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 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.
- To find a provider in the Anthem PPO network, please visit www.anthem.com/ca/sisc

Q3: 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 life event Online via BenefitBridge if active (www.benefitbridge.com/Peralta). For Retirees, please contact the Benefits Office at benefits@peralta.edu |call (510) 466-7229 no later than 31 days after your life event.

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

Furthermore, if you are an employee who is eligible for coverage but not enrolled, you shall be eligible to enroll for coverage within 60 days after (a) becoming ineligible for coverage under a Medicaid, Children's Health Insurance Plan (CHIP); or (b) being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan. Employers that sponsor group health plans must notify employees of any premium assistance that is available to them under a Medicaid or CHIP plan with respect to coverage under the plan. For additional information, please reference page 51, HIPAA Notice of Special Enrollment Rights.

Q4: 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.

Q5: 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.

Q6: 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.

Q7: Domestic Partners & Imputed Income - if I add a domestic partner to the coverage, how is my paycheck 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 gross**
Federal	$1,708.00	$872.00	$872.00
California State*	$1,708.00	$872.00	$0.00*

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

Q8: 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

Q9: How do I change my address with my medical or dental plan?

A: If you are active, use the self-service feature on Peralta Human Capital Management (HCM) System or download and complete the change form. https://www.peralta.edu/hr/personal-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 Peralta Colleges, Human Resources, Attention: Address Changes, 333 East 8th Street, Oakland, CA 94606.

Q10: How do I enroll in group medical and dental insurance with Peralta?

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

SURVIVING SPOUSE OF RETIREES

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 whom are monthly premiums paid?

Carrier	Premiums are paid to
SISC Medical Plans (Anthem and Kaiser)	Navia Benefits PO Box 53250 Bellevue, WA 98015 Fax: 425-451-7002
Retiree First Plans (Anthem MAPD and United American)	
United Health Care (UHC) Dental	
Delta Dental (Plans 938 & AB 528)	

4. Who is Navia? Navia is the third-party administrator for the District's
    - Medicare Premium Reimbursement Plan
    - Medical and Prescription Reimbursement plans
    - COBRA benefits
    - Flexible benefit plans under IRS codes 105, 125 and 132
    - Retiree HRA for Medical & Prescription Drugs (SISC Kaiser & SISC Medical Plans)
5. Are survivors eligible for the Medicare Reimbursement program? Yes, only Survivors of lifetime members are eligible for reimbursement (Hired before 07/01/2004).
6. Are survivors eligible for the Retiree HRA for Medical & Prescription Drugs (SISC Kaiser & SISC Medical Plans reimbursement program? Yes, only Survivors of lifetime members are eligible for reimbursement (Hired before 07/01/2004).
7. Does Peralta pay premiums for surviving spouses of Peralta retirees? No.

MEDICARE ENROLLMENT FAQS

	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 Benefit Office	
4. Does Kaiser assess a penalty for late Kaiser Senior Advantage enrollment?	No; if active employee not required to enroll in Kaiser Senior Advantage	No
5. What are the benefits for the retiree who enrolls in the Kaiser Senior Advantage (dental)?	Not Applicable	Peralta currently bundles Delta Care (DHMO)
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. Upon retirement, you are required to be enrolled in Medicare A & B by the 1st of the following month.
7. To who are Medicare premiums paid?	Active employees can defer Part B until retirement.	Medicare premiums are normally deducted from Social Security checks or can be paid directly to Social Security.
8. Who is eligible for reimbursement of Medicare premiums?	Not Eligible.	Lifetime 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 SISC Anthem 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

*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
Retiree First	855-460-7312	https://retireefirst.com/PeraltaCCD/
Navia	877-920-9675	www.naviabenefits.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).
- Please contact the Benefits Office to complete the applicable form(s) 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, you may schedule an Exit Interview with Human Resources and a Retirement 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 forms and documents for the continuation of medical benefits, if eligible
    - Collective Bargaining Agreement

Within 60-days (after retirement)

- Complete the COBRA Election Notice to continue the benefits beyond retirement effective date

POST-RETIREMENT CHECKLIST

HRA Medical & Prescription Reimbursements

Retirees and eligible dependents should submit eligible expense no later than 1 year after the date of service to Navia Benefits Solutions. Call 866.857.1996

Annually

- Inform the district's agent (Navia) of your Medicare premium amount for reimbursement

Within 30-days

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

Survivor's Checklist

- Notify the Benefits Office no later than 31 days of the retiree's death. Call 510.466.7229
- 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

MEDICAL AND PRESCRIPTION REIMBURSEMENTS

Peralta Community College District is pleased to announce that Navia will now be managing Health reimbursements for eligible retirees on a SISC medical plan starting April 1, 2024.

Please ensure that Navia and the District Benefits Office have your updated address and phone number.

1. Starting April 1, 2024, you will no longer submit Health reimbursement forms to the District Benefits Office.
2. The District will process any request for Health reimbursements that you are eligible for that were submitted to the Benefits Office before April 1, 2024.
3. Navia will also continue Medicare A, B and D premium reimbursements as well once a month.

- **What is needed for Navia Benefit Solutions to process my claim?**
  We will need an Explanation of Benefits (EOB)/receipt from your Primary Insurance Carrier detailing the patient's name, date of service, type of cost and the applicable deductible/coinsurance/copayment information.

  The claim must be considered by the Primary Insurance Carrier before Navia can process and consider the claim.
- **How can I submit my claims to Navia?**
  We have several methods of submission for claims available.
  Need Assistance? Call 559-256-1320 or Toll-Free 866-777-1320 or
  email us at sps@naviabenefits.com
  Fax – 559.475.5780
  Mail – Navia Benefits Solutions, P.O. Box 5809 Fresno, CA 93755
  Email* – spsclaims@naviabenefits.com
- **What is a Health Reimbursement Arrangement (HRA) plan?**
  A Health Reimbursement Arrangement is a plan that is funded by The District. You and your eligible dependents may be reimbursed for qualifying medical expenses up to the amount shown on your Schedule of Benefits. HRAs are a tax-free benefit.
- **Who can I reach out to if I have questions about my claims or plan benefits?**
  Navia's Scheduled Plan Services (SPS) team of experts are committed to addressing all your inquiries.

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located in this guide:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

Medicare Part D Notice

Important Notice from 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 is, 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 A 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 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 person 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 (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 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:	October 1, 2024
Name of Entity/Sender:	Peralta Community College District
Contact-Position/Office:	Phoenix Lara – District Benefits Manager
Address:	333 East 8th Street Oakland, CA 94606
Phone Number:	(510) 466-7229

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 you or 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 you become 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.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

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, 2024. 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: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | 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 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
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 | HIPP Phone: 1-800-967-4660
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://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
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 | email: HHSHIPPProgram@mt.gov
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/programs-services/medicaid/health-insurance-premium-program 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/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | 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://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services 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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
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, 2024, 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

GENERAL NOTICE OF COBRA CONTINUATION RIGHTS

INTRODUCTION

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

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

COBRA CONTINUATION COVERAGE

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

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

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

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

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

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

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

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

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

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

COBRA continuation coverage is temporary continuation coverage. When the qualifying 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.

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: Phoenix Lara (510) 466-7229, Address: 333 East 8th Street, Oakland, CA 94606


PERALTA COMMUNITY
COLLEGE DISTRICT