Health Benefits Fringe Committee Meeting

October 11, 2012
Board Room

Peralta Community College District
Health Benefits Fringe Committee
Meeting-Thursday, October 11,
2012

Agenda

1. Introductions & Focus of Committee

   (10:00-10:10)

2. Review of Handouts

   (10:00 – 10:15)

   - Fall Newsletter
   - List of changes to Self-funding Plan 2006 – 2008
   - Open Enrollment Announcement for the Flexible Benefits Plan
   - Benefits Fair Flyer –Save the Date Thursday, November 15!
   - Health Care Reform Timeline from Mercer

3. State of the Budget, Vice Chancellor Gerhardt

   (10:15-10:30)

4. Review of outstanding issues from the Spring, Benefits Office Staff

   (10:30-10:40)

   1. Medicare Coordination
   2. Rate determination for surviving spouses
   3. Buy-in-to retiree benefits
   4. JPA Exploration

5. JPA Exploration

   (10:45-11:15)

6. Review of Health Care Reform/Patient Protection Act Implementation Timeline

   (11:15 – 11:30)

Lunch

7. JPA Exploration

   (11:30 – 12:15)

<u>Agenda Items for next meeting Thursday 11/8/12</u>

1. Next Meeting dates for the semester 11/8 and 12/3
2. Review of Medicare Coordination Notices to retirees and to union
3. Review of compliance issues
4. More Discussion on JPA Exploration
5. Other Topics

Peralta Community College District
Health Benefits Fringe Committee
Meeting-Thursday, October 11,
2012

1. Introductions and Focus of Committee

- Introductions
- Focus of the Committee: Based on Collective Bargaining excerpts
  - Focus of the Committee-advisory, collaborative in nature.
  - The parties agree that a study committee shall be established to study manners and mechanisms which will reduce the impact of health and welfare costs to the District. The study committee shall consist of representatives from PFT, SEIU Local 1021, IUOE Local 39 and Management (and the Peralta Retirees Organization) to review potential changes and/or modification to health and welfare plans. The role of the Committee shall be limited to making recommendations to the unions and the District… 1021.
  - Review potential changes and/or modifications to health and welfare plans

2. Review of Handouts/Announcements

1. Fall Newsletter
   - Distribution during week of October 22
   - Feedback by Monday, Tuesday, October 16

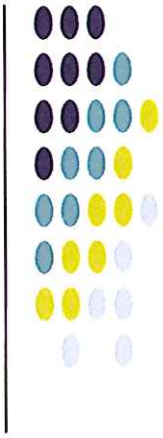
2. List of changes to Self-funding Summary Plan description since 2006
   - Many due to change in vendor, compliance with external changes (covering dependents to age 26, mental health parity, etc), administrative change or correction (changing reference of local 790 to 1021)

3. Open Enrollment Announcement for the Flexible Benefits plan
   - Required to bring flexible benefit plan 125 in synch with medical plan renewals
     - 2 enrollments
       - January 2013- June 2013 (Short Plan Year)
       - July 2013– June 2014 (Aligned with Fiscal Year)

4. Benefits Fair Flyer-Save the Date November 15,
   - Highlighting
     - Flexible Benefits Plan under IRS code 125
     - Voluntary Benefits
     - Health Club memberships

5. Health Care Reform Update: Benefits Office (***Mercer Key Elements of Health Reform for Employers)***

3.State of the Budget- Vice Chancellor Gerhardt



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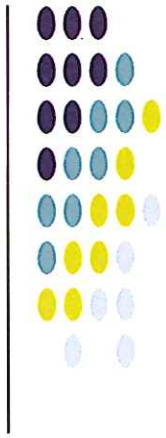
4. Follow up Items from the Spring 2012

Follow up items from the spring:

1. Explanation of how survivor rates are determined (Peralta Retiree Organization)
2. Medicare coordination for retirees- follow up all 3 draft of communications next meeting-
3. Buy-in options for non-benefit eligibles (part time hourly faculty and other active employee groups) 39 & Peralta Federation of Teachers
4. Exploration of network options for non-California retirees
5. Joint Power Authority Exploration –

4.1-How are survivor rates determined-self funded plan



- Self-funded plan-Currently Administered by CoreSource, using the Anthem Blue Cross Network

  There are 3 pools within Peralta CCD for calculating rates:

  actives,

  retirees under 65, and

  retirees over 65.

  The surviving spouses are included in the retiree pools depending on whether they are under or over 65.

4.1 How are survivor rates Kaiser HMO

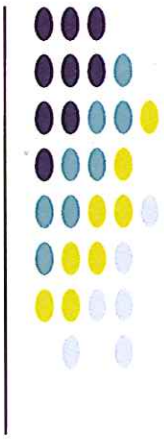
Below are the responses for the questions below.

Surviving Spouse over 65 (From retiree over 65)
In this case, when the subscriber and dependent are both over 65 and enrolled in Kaiser Permanente Senior Advantage (KPSA) and the subscriber dies, Perlata would no longer pay the 2 party KPSA rate, but instead pay the single party KPSA rate for the surviving spouse. The KPSA Medicare rates are community rate and based on Kaiser Permanente's total Northern California Medicare enrollment.

Surviving Spouse under 65 (From retiree over 65)
In this case, when the subscriber is over 65 and the dependent is under 65, the dependent would be enrolled in the retiree enrollment unit, but enrolled in the Traditional HMO plan. In this case, the surviving dependent would continue to be pooled with the other under 65 retiree population which is combined with the Active employee population, and the surviving spouse would be charged the Active employee rate.

Surviving Spouse under 65 (From retiree under 65)
In this case, the surviving spouse would continue to be charged the Active employee rate. The only difference is now they would be the subscriber. In this case, the surviving dependent would continue to be pooled with the Active/under 65 retiree population and would be charged the Traditional HMO subscriber rate.

4.5 Joint Powers Authority (JPA)



- What is a JPA?

A JPA is an entity of two or more public agencies which can operate collectively for the purpose of improving buying power (of health insurance).

- Why a JPA now?

In short, if Peralta considers joining a consortium of school districts which offers a Kaiser plan design like ours, maybe we can:

  - receive a better pricing due to economies of scale and
  - recognize stabilized rate fluctuations. We are already part of a JPA for dental insurance.

- Perhaps other issues could be addressed through a JPA (medical plan buy-in, out of California medical plan networks.

JPA Objectives

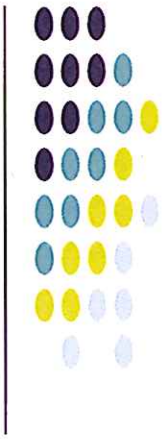
- Facing an 18% increase from Kaiser, during fiscal year 2012-2013, we need to find a mechanism to stabilize our risk and future increases

JPA Different Models

- We can join a JPA with or without broker or consultant representation.
- We can forgo a broker/consultant and join a JPA directly.
- We can continue to use a broker/consultant for proper marketing of the Peralta population.

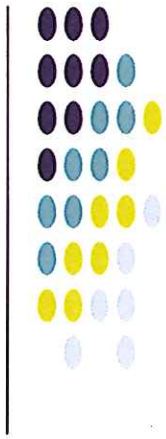
4.5 JPA Considerations

until 10:40



1. Will the products offered by a JPA match our current offerings to our employees
2. What is the ease of entry into a JPA (can you only join during certain windows)
3. Ease of transition (electronic/paper/telephone)
4. What is the ease of exit if the arrangement does not fit the culture?
5. Is there a minimal duration of commitment?
6. Would we sacrifice our Medicare D Subsidy?
7. Level of customer service to our employees/retirees
8. How comprehensive are the offerings beyond medical (Possible savings reductions in other areas: life, ltd, buy-in options)
9. Ability to provide options for non-California residents

JPA Exploration



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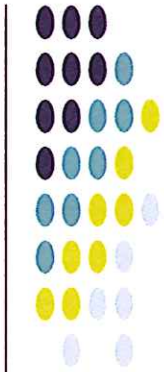
Health Care Reform-An update/Review

1. Review and Discussion of Health Care Reform /Patient Protection Act Implementation Timeline

Highlights below: See attachment Mercer Timeline

- 2012
  - Required distribution of uniform Summary of Benefits and Coverage to participants for plan years renewing after 9/23/12
  - 60-day advance notice of mid-year material modifications to SBC content
  - Form w-2 reporting for health coverage (track in 2012 for IRS Form W-2 form provided in year 2013
- 2013
  - $2,500 Flexible Spending Account Contribution Max
  - Higher Medicare Payroll Tax on wages exceeding $200,000
  - Retiree Drug Subsidy becomes taxable to employers
- 2018
  - Cadillac Tax ~ 40%

JPA Exploration-Lunch



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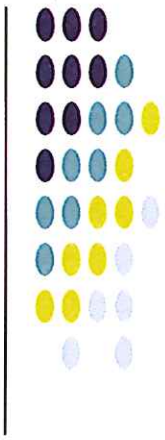
Agenda Items for Next Meeting



- Review of Medicare Coordination Notice
- Review of other compliance issues
- More discussion on JPA
- Other Topics?
- Ytd budget expenditures?
- Census update?

PERALTA BENEFITS – EVERYONE

Published by the PCCD Benefits Office

October 9, 2012

Peralta Community College District Benefits Office

333 East 8th Street

Oakland, CA 94606

2011-2012 Accomplishments:

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

A year of changes.....

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

But what remains the same?

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

Health Care Reform
W-2's issued in 2012
If you are retired from Peralta, are covered under our group insurance plan, and return to work at Peralta, we are required to report the value of your insurance on Peralta's issued W-2 document.

Open Enrollment for the Flexible Benefits Plan will occur from November 1 – November 30, 2012 for the SHORT plan year January 1 – June 30, 2013. Why the change now? We are aligning the plan year to be consistent with our other health plan renewals.

Customer Service

The District Benefits Office provides support for over 2,000 active and retired employees and their eligible dependents. We encourage the use of District resources and technologies to increase your access to information and service.*

PSW Benefit Resources (for medical, dental, life and disability)
In addition to the Benefits Office, District resources include, but are not limited to: PSW Benefit Resources assists employees and retirees of the District with the resolution of service issues for District-sponsored group medical, dental, life and disability plans. The PSW Benefit Resources customer service team helps with escalated claims issues with our carriers, clarification of eligibility rules and other compliance and regulatory matters as they arise. ***877.866.2623***

MidAmerica Services (for the tax-deferred plans)
MidAmerica assists with the administration of our tax-deferred 403(b) and 457 Plans. If an employee wants to begin, change or transact on a tax-deferred account with Peralta, MidAmerica can help facilitate transactions on behalf of the District. As third-party administrator, MidAmerica's role is to ensure that our employees and the District are in compliance with external regulations affecting tax deferred investments. ***800.634.1178***

**See page 9 for other useful resources*

Websites

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

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

Did you know...

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

Inside this issue:

Benefits Overview
Fall 2012

Vendor	Information on Vendors
KAISER PERMANENTE	**Kaiser Medical Plan (Health Maintenance Organization - HMO); www.kp.org** • All employees except Local 39 employees Kaiser provides medical care through participating doctors at Kaiser facilities. The plan emphasizes preventive care and provides most services and supplies at little to no cost to you. The plan includes coverage for prescription drugs and optical services obtained at a Kaiser facility. The District plan allows for a $10 co-pay for most services. **Pharmacy benefits** Retail and mail order is covered up to a 100 day supply at a $10 co-pay for generic formulary or a $15 co-pay for a brand name formulary. • Local 39 employees only Kaiser provides medical care through participating doctors at Kaiser facilities. The plan emphasizes preventive care and provides most services and supplies at little to no cost to you. The plan includes coverage for prescription drugs and optical services obtained at a Kaiser facility. The District plan allows for a $15 co-pay for most services. **Pharmacy benefits** Retail up to 30 day supply at a $10 generic or $20 for brand name formulary prescription. Mail order is covered up to a 100 day supply at a $20 co-pay for generic formulary or a $30 co-pay for a brand name formulary.
PERALTA COMMUNITY COLLEGE DISTRICT CORESOURCE Anthem. Health Join In. CVS CAREMARK UnitedHealthcare	**Peralta PPO Medical Plans (Preferred Provider Organization - PPO), administered by CoreSource; www.coresource.com** • All employees except Local 39 employees CoreSource is the administrator of the medical services received through the Anthem Blue Cross network (California residents) or PHCS network (non-California residents). To access Anthem Blue Cross providers, go to www.anthem.com/ca. The PPO provides coverage for routine and major medical services received through network providers. Most office visits are available after a $10 co-pay per visit. **Pharmacy benefits can be accessed through CVS / Caremark. www.caremark.com.** Must use contracting pharmacy vendors ONLY! Retail is covered up to a 30 day supply at a $10 co-pay for generic prescription or a $15 co-pay for a brand name prescription. Mail order is covered up to a 90 day supply at a $5 co-pay for either generic or brand name prescriptions. • Local 39 employees only CoreSource is the administrator of the medical services received through the Anthem Blue Cross network (California residents) or PHCS network (non-California residents). To access Anthem Blue Cross providers, go to www.anthem.com/ca. The PPO provides coverage for routine and major medical services received through network providers. Most office visits are available after a $15 co-pay per visit. **Pharmacy benefits can be accessed through CVS / Caremark. www.caremark.com.** Must use contracting pharmacy vendors ONLY! Retail is covered up to a 30 day supply at a $10 co-pay for generic prescription or a $20 co-pay for a brand name prescription. Mail order is covered up to a 100 day supply at a $20 co-pay for generic prescription or $30 co-pay for brand name prescription. **Vision benefits for all Peralta PPO Plans can be accessed through UnitedHealthcare Vision; www.myuhcvision.com.** Participants can receive benefits through the United Healthcare Vision network of providers and can receive out of network benefits within the plan guidelines. Office visit co-pays are $10 for examinations.
DELTA DENTAL	**Delta Dental Plan (Preferred Provider Organization - PPO); www.deltadentalins.com** Delta Dental pays 100% for most services, including preventive care, fillings, extractions, crowns, periodontics, and root canal work. Bridges and dentures are covered at 50%. The plan pays up to $1,500 per person per calendar year. Orthodontia coverage is available for dependent children up to age 26. It is paid at 50% up to a calendar year maximum of $1,000 per person.
UnitedHealthcare Dental	**United HealthCare Dental Plan (Dental Maintenance Organization - DMO); www.myuhc.com** United HealthCare Dental pays 100% for most services. In addition to routine cleanings, examinations and x-rays, this plan has an added feature of child AND adult orthodontia. Plan surcharge for orthodontia is $2,250 when using a United HealthCare DMO dentist.
	**Flexible Benefits Plan & Pre-Tax Commuting Reimbursement; www.pensiondynamics.com** Medical and/or Dependent Care Expense (IRS Section 125): Eligible employees can set aside tax free dollars for out of pocket medical expenses or dependent day care expenses. First, set the money aside from each paycheck, then submit receipts to recover tax free dollars. Check with a tax professional to learn if this option is feasible to your personal situation. Pre-Tax Commuting Expense (IRS Section 132): If public transportation is used to get to and / or from work, this account can be used to reimburse specified expenses with pre-tax dollars.
ING	**Long Term Disability Insurance; www.ing.com** If a covered disability prevents you from working for more than 90 calendar days, the District's Long Term Disability plan, through ING, pays a monthly benefit of up to 60% of your base monthly earnings, up to a $5,000 per month maximum benefit. Benefits are payable while disabled (after all payable sick leave and other available leaves have been exhausted), within certain time limits specified in the policy. PCCD employees do not pay into State Disability Insurance.
ING	**Basic Term Life and Accident (AD&D) Insurance; www.ing.com** The District provides, at no cost to the employee, a life insurance benefit through ING equal to 150% of your base salary (subject to a $100,000 maximum benefit) for employees, $1,000 for spouses, and $100 for each dependent (birth to age 6 months) or $500 for each dependent (from age 6 months to 22 years). The plan includes an amount equal to the life insurance benefit in the case of accidental death, or a percentage of that amount for accidental loss of sight or limb(s). Life insurance terminates when the employee reaches age 66 unless the employee is still actively employed. The plan can be converted to an individual plan at the retiree's expense.
CIGNA	**Voluntary Term Life Insurance; www.cigna.com** You may apply for additional (voluntary) insurance up to $500,000 for you, your spouse and unmarried dependent children. Coverage is guaranteed if you are a new hire and you apply within 31 days of becoming a benefit eligible employee. Late enrollees will be subject to full evidence of good health.

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

Plan	Peralta PPO "Traditional" In-Network	Peralta PPO "Traditional" Out-of-Network	Peralta PPO "Lite" In-Network ONLY	Kaiser HMO In-Network ONLY
Calendar Year Deductible: (deductibles cross accumulate)	$100 per person; 3 times individual deductible per family			None
Out of Pocket Maximum:	$300 per person; $900 per family	$1,000 per person; $3,000 per family	$300 per person; $900 per family	$1,500 per person; $3,000 per family
Lifetime Maximum Benefit:	Unlimited			Unlimited
Pre-Existing Condition	6 months if enrolling when first eligible or 18 months if enrolling anytime thereafter. Limitation may be reduced by prior Creditable Coverage. No pre-existing condition limitations for anyone under the age of 19			None
Network:	California residents access Anthem Blue Cross (www.anthem.com/ca); non-California residents access PHCS (www.phcs.com)	Not applicable	California residents access Anthem Blue Cross (www.anthem.com/ca); non-California residents access PHCS (www.phcs.com)	Kaiser
Physician Office Visits:	$10 co-pay (deductible waived)	80% of usual and customary fees, after calendar year deductible	$10 co-pay (deductible waived)	$10 co-pay
Diagnostic Testing, X-Rays and Laboratory:	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	100% of negotiated rates, after calendar year deductible	100%
Inpatient Hospitalization:	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	100% of negotiated rates, after calendar year deductible	100%
Pre-Certification of Inpatient Services:	Required. Penalty is 25% reduction of benefits. Does not apply to maternity or emergency visits.			Required. Penalty is 100% reduction of benefits. Does not apply to maternity or emergency visits.
Emergency Room Visits:	$35 co-pay (deductible waived). Co-pay will be waived if admitted to the hospital.			$35 co-pay. Co-pay will be waived if admitted to the hospital.
Out of Area Benefits:	If no contracting providers are within 30 miles of your residence, providers are considered in-network. Call CoreSource about water and/or mountain barriers.			Limited to life threatening emergency treatment only.
Vision Plan:	See United Healthcare Vision brochure for schedule of Network and non-Network vision benefits (www.myuhcvision.com)			Vision exam covered under medical plan. Materials benefit limited to $175 allowance per 24 month period.
Prescription Coverage:	Must use contracting pharmacy vendors ONLY! Retail is covered up to a 30 day supply at a $10 co-pay for generic prescription or a $15 co-pay for a brand name prescription. Mail order is covered up to a 90 day supply at a $5 co-pay for either generic or brand name prescriptions. Retail Pharmacy Note - if a brand name drug is prescribed and there is no generic equivalent, then the member will ONLY pay the generic co-pay.			Retail and mail order is covered up to a 100 day supply at a $10 co-pay for generic formulary or a $15 co-pay for a brand name formulary.

Check out your Benefits Information Center (BIC) – to learn more about your benefits, please visit your Benefits Information Center (BIC) website at: www.peralta.pswbenefits.net,

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

Plan	Peralta PPO "Traditional" In-Network	Peralta PPO "Traditional" Out-of-Network	Peralta PPO "Lite" In-Network ONLY	Kaiser HMO In-Network ONLY
Calendar Year Deductible: (deductibles cross accumulate)	$100 per person; 3 times individual deductible per family			None
Out of Pocket Maximum:	$300 per person; $900 per family	$1,000 per person; $3,000 per family	$300 per person; $900 per family	$1,500 per person; $3,000 per family
Lifetime Maximum Benefit:	Unlimited			Unlimited
Pre-Existing Condition	6 months if enrolling when first eligible or 18 months if enrolling anytime thereafter. Limitation may be reduced by prior Creditable Coverage. No pre-existing condition limitations for anyone under the age of 19			None
Network:	California residents access Anthem Blue Cross (www.anthem.com/ca); non-California residents access PHCS (www.phcs.com)	Not applicable	California residents access Anthem Blue Cross (www.anthem.com/ca); non-California residents access PHCS (www.phcs.com)	Kaiser
Physician Office Visits:	$15 co-pay (deductible waived)	80% of usual and customary fees, after calendar year deductible	$15 co-pay (deductible waived)	$15 co-pay
Diagnostic Testing, X-Rays and Laboratory:	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	100% of negotiated rates, after calendar year deductible	100%
Inpatient Hospitalization:	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	100% of negotiated rates, after calendar year deductible	100%
Pre-Certification of Inpatient Services:	Required. Penalty is 25% reduction of benefits. Does not apply to maternity or emergency visits.			Required. Penalty is 100% reduction of benefits. Does not apply to maternity or emergency visits.
Emergency Room Visits:	$35 co-pay (deductible waived). Co-pay will be waived if admitted to the hospital.			$35 co-pay. Co-pay will be waived if admitted to the hospital.
Out of Area Benefits:	If no contracting providers are within 30 miles of your residence, providers are considered in-network. Call CoreSource about water and/or mountain barriers.			Limited to life threatening emergency treatment only.
Vision Plan:	See UnitedHealthcare Vision brochure for schedule of Network and non-Network vision benefits (www.myuhcvision.com)			Vision exam covered under medical plan. Materials benefit limited to $175 allowance per 24 month period.
Prescription Coverage:	Must use contracting pharmacy vendors ONLY! Retail is covered up to a 30 day supply at a $10 co-pay for generic prescription or a $20 co-pay for a brand name prescription. Mail order is covered up to a 100 day supply at a $20 co-pay for either generic or $30 brand name prescriptions. Retail Pharmacy Note - if a brand name drug is prescribed and there is no generic equivalent, then the member will ONLY pay the generic co-pay.			Retail up to 30 day supply at a $10 generic or $20 for brand name formulary prescription. Mail order is covered up to a 100 day supply at a $20 co-pay for generic formulary or a $40 co-pay for a brand name formulary.

Check out your Benefits Information Center (BIC) – to learn more about your benefits, please visit your Benefits Information Center (BIC) website at: www.peralta.pswbenefits.net,

Dental Plan Highlights
Delta Dental PPO Dental Plan – United Healthcare DMO Dental Plan
Effective July 1, 2012

Plan	Delta Dental	United HealthCare
Network:	Delta Dental www.deltadentalins.com Delta Premier Select: Find a dentist Select: Delta Dental Premier	United HealthCare Dental www.myuhc.com Select: "Locate dentist" Select: "dbp of California Pacific Union Dental" DMO Dental Plan (HMO plan)
Out of Network:	Okay, but is limited to Delta Dental's usual & customary fees	Not permitted. Must use United HealthCare Dental dentists ONLY.
Deductible:	None	None
Diagnostic & Preventative Services: (oral examinations, cleanings, x-rays)	Network: 100% of negotiated rate non-Network: 100% of usual & customary fees; (balance billing may occur)	Network: 100% of United HealthCare fees non-Network: No coverage available
Basic Services: (extractions, biopsies, fillings, root canals, sealants, gum treatment) - *both plans charge the patient if asked for resin or porcelain on molars, or if asked for a higher level metal than what is considered dentally appropriate.*	Network: 100% of negotiated rate non-Network: 100% of usual & customary fees; (balance billing may occur)	Network: 100% of United HealthCare fees non-Network: No coverage available
Crowns, Jackets, Other Cast Restorations - *both plans charge the patient if asked for resin or porcelain on molars, or if asked for a higher level metal than what is considered dentally appropriate.*	Network: 100% of negotiated rate Non-Network: 100% of usual & customary fees; (balance billing may occur)	Network: 100% of United HealthCare fees Non-Network: No coverage available
Prosthodontic Services: (bridges, partial and full dentures)	Network: 50% of negotiated rate Non-Network: 50% of usual & customary fees; (balance billing may occur)	Network: 100% of United HealthCare fees Non-Network: No coverage available
Calendar Year Maximum (Per Person):	$1,500	Unlimited
Orthodontia Services:	Dependent children only to age 19; Network: 50% of negotiated rate Non-Network: 50% of usual & customary fees Benefits limited to a separate $1,000 per person per calendar year maximum	100% of United HealthCare fees not to exceed $2,250 in patient co-pays. Benefits available to children and adults

Check out your Benefits Information Center (BIC)

To learn more about your benefits, please visit your Benefits Information Center (BIC) website at: www.peralta.pswbenefits.net

Benefits Matrix

Benefit Matrix	Benefit Classification as Defined by Benefit Program Assignment

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

Check out your Benefits Information Center (BIC)

To learn more about your benefits, please visit your Benefits Information Center (BIC) website at: www.peralta.pswbenefits.net

Benefits for All Active Employees

WORKERS' COMPENSATION INSURANCE

All District employees are automatically covered by workers' compensation benefits. If an employee is injured while on the job and if the claim is accepted by the District's workers' compensation claims administrator, the benefits include coverage for medical and rehabilitation expenses associated with the injury. The District provides full salary for the first 60 days, under the Peralta Industrial Leave policy. Our claims are administered through York RSG. Medical services are rendered through the WellComp medical network with many providers and specialists in the area.

Refer to plan booklets for other information on the benefits of retirement plan participation. In addition to retirement income, each plan may offer other pre-retirement planning opportunities (long-term care, home loan programs and more).

RETIREMENT PLANS (PERS, APPLE, STRS, Cash Balance)

Depending on your position and your appointment, you participate in either the Public Employees' Retirement System (PERS), the State Teachers' Retirement System (STRS) or the APPLE Plan. Inquire with Human Resources or each respective retirement plan system regarding plan membership

The employee contributes 7% of salary, and this contribution is tax-deferred. The District currently contributes 11.416% of salary to the members' PERS retirement fund.

Employees who are part time, seasonal or temporary may be eligible for the Accumulation Program for Part-time and Limited Service Employees (APPLE). Your mandatory contribution is 3.75% of eligible salary; the District contributes 3.75% of your eligible salary to this plan.

The contribution rate is based on the academic term (10, 11 or 12 month) assigned to the faculty member and is tax deferred. The District currently contributes 8.25% of the member's annual salary to the STRS fund (refer to the Monthly Contribution Table enclosed).

Part time educators may be eligible for participation in the defined benefit plan Cash Balance Benefit Program. Both the employee and employer contribute 4% of salary to this retirement fund.

VOLUNTARY 403(b) & 457 PLANS

Tax Shelter Programs & Personal Financial Planning

Under Section 403(b) of the Internal Revenue Code and Section 17512 of the California Revenue and Taxation Code, Peralta employees may participate in the District's tax shelter programs. We also offer tax-deferred savings opportunities through the 457 plan. Maximize your tax savings and minimize your tax liability through these plans! Meet with your personal financial planner or tax-preparer to review how these benefits fit into your future planning. Contact Christine Ingoldsby regarding upcoming workshops scheduled for Peralta. She can be reached at 800.660.6291.

LABOR UNIONS

Unions/Associations

These unions and associations represent the employees in contract negotiations with the District concerning issues such as salary, benefits, hiring practices, working conditions, etc.

Monthly dues:

- Peralta Federation of Teachers *(www.pft1603.org)*
- Regular/Contract/Accelerated Faculty: 0.01600 of any gross salary (plus approved AFT/CFT pass-throughs)
- Hourly Part-time Faculty:

  $17.76 for each month of employment for three (3) equated hours or less (plus approved AFT/CFT pass-throughs)
  $30.88 for more than three (3) equated hours (plus approved AFT/CFT pass-throughs)

- Local 1021 of the service Employee International Union *(www.seiu1021.org)*

  1.70% of base salary
  1.07% of base salary for temporary employees.

- International Union of Operating Engineers, Local 39 of the AFL-CIO *(www.local39.org)*

  Monthly dues are twice the hourly rate plus $8.25.

Reimbursement Programs

KAISER REIMBURSEMENT PROGRAM FOR MAIL ORDER PRESCRIPTONS	
Eligibility:	Active and post 07/01/04 retired members of unions, PFT, 1021, 39; confidential and management employees
Frequency of Reimbursement:	Semi Annually (July and January)
Documentation Guidelines:	Complete Kaiser Reimbursement Form and supply receipts (download form at www.peralta.pswbenefits.net under the Medical / Kaiser HMO link)
MEDICARE PART A and/or PART B REIMBURSEMENT PROGRAM	
Eligibility:	Retirees & spouses (or domestic partner) over age 65 and paying for Medicare Part A and/or Part B
Frequency of Reimbursement:	Monthly –subject to the timing of our receipt of your documentation.
Documentation Guidelines:	Annual and periodic verification of monthly premium amount, based on retiree's payment method to Center for Medicare and Medicaid Services (CMS)
KAISER OFFICE VISITS & PRESCRIPTION DRUG CO-PAYS (INCLUDING MAIL ORDER PRESCRIPTION DRUG CO-PAYS)	
Eligibility:	Pre July 1, 2004 retirees
Frequency of Reimbursement:	Semi-Annually (July and January)
Documentation Guidelines:	Complete Kaiser Reimbursement Form and supply receipts (download form at www.peralta.pswbenefits.net under the Medical / Kaiser HMO link)
KAISER REIMBURSEMENT PROGRAM FOR MAIL ORDER BRAND NAME PRESCRIPTONS	
Eligibility:	Active and post July 1, 2012 Local 39 retirees / employees
Frequency of Reimbursement:	Semi Annually (July and January)
Documentation Guidelines:	Complete Kaiser Reimbursement Form and supply receipts (download form at www.peralta.pswbenefits.net under the Medical / Kaiser HMO link)

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

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

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

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

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

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

Important References and Resources

Insurance & Carrier Contact Information

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

Benefits of Belonging to Peralta Community College District

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

Frequently Asked Questions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A:. Your eligible dependents are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Comparison of Governmental 457 Plans to 403(b) Plans

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

1195 Park Avenue, Suite 205
Emeryville, CA 94608
800-660-6291

22956 El Toro Rd.
Lake Forest, CA 92630
888-488-8480

www.zukfinancial.com

ZUK
FINANCIAL GROUP
The Educated Choice

How do I know that my employee contributions are correct?

2012-2013 Monthly Contribution Rate Matrix for

Active, Benefit-Eligible Employees

Medical Coverage for All Regular Employees (Except Local 39)				Medical Coverage for Local 39 Employees		
Single Party Coverage	Kaiser HMO	PPO Lite	PPO Traditional	Kaiser HMO	PPO Lite	PPO Traditional
Employee Pays	**0.00**	**15.00**	**62.55**	**0.00**	**15.00**	**44.19**
Peralta Pays	622.64	651.55	666.55	609.25	633.22	666.21
Total Cost	622.64	666.55	729.10	609.25	648.22	710.40
Two- Party Coverage	Kaiser HMO	PPO Lite	PPO Traditional	Kaiser HMO	PPO Lite	PPO Traditional
Employee Pays	**0.00**	**30.00**	**139.75**	**0.00**	**30.00**	**111.68**
Peralta Pays	1,245.27	1,459.24	1,489.24	1218.50	1418.29	1475.54
Total Cost	1,245.27	1,489.24	1,628.99	1218.50	1448.29	1587.22
Family Coverage	Kaiser HMO	PPO Lite	PPO Traditional	Kaiser HMO	PPO Lite	PPO Traditional
Employee Pays	**0.00**	**45.00**	**209.95**	**0.00**	**45.00**	**167.79**
Peralta Pays	1,762.06	2,192.32	2,237.32	1724.18	2130.80	2216.73
Total Cost	1,762.06	2,237.32	2,447.27	1724.18	2175.80	2384.52

Dental Coverage for Managers & Confidentials (Except Confidentials who elected furlough)			Dental Coverage for Regular Represented Employees in Local 39, 1021, PFT	
Single Party Coverage	Delta Dental	United Health Care Dental	Delta Dental	United Health Care Dental
Employee Pays	**47.34**	**0.00**	**0.00**	**0.00**
Peralta Pays	26.95	26.95	74.29	26.95
Total Cost	74.29	26.95	74.29	26.95
Two- Party Coverage	Delta Dental	United Health Care Dental	Delta Dental	United Health Care Dental
Employee Pays	**83.19**	**0.00**	**0.00**	**0.00**
Peralta Pays	43.11	43.11	126.30	43.11
Total Cost	126.30	43.11	126.30	43.11
Family Coverage	Delta Dental	United Health Care Dental	Delta Dental	United Health Care Dental
Employee Pays	**127.48**	**0.00**	**0.00**	**0.00**
Peralta Pays	65.69	65.69	193.17	65.69
Total Cost	193.17	65.69	193.17	65.69

Other PCCD Statutory Benefit Costs

Other PCCD Benefit Costs		
Benefit Plan	**Employee Cost**	**Employer Cost**
Basic Life & AD&D	$0.000	$.221 / $1,000 of salary
Long Term Disability	$0.000	$.17 / $100 of salary
Dependent Life Insurance	$0.000	$.350 per dependent unit
Employee Assistance Plan	$0.000	$2.21 per family unit
State Teacher Retirement System (mandatory retirement plan)	Contribution based as a percentage of salary	
10 Month Academic Appointment	9.600	8.250
11 Month Academic Appointment	8.727	8.250
12 Month Academic Appointment	8.000	8.250
Cash Balance Plan (retirement plan for part-time faculty)	4.000	4.000
Public Employees Retirement System (PERS)	7.000	10.93 ~~11.416~~
Accumulation Program for Part-time and Limited Service Employees (APPLE); managed by MidAmerica	3.750	3.750
Social Security (for first $106,800 in PCCD wages)	6.200	6.200
Medicare	1.450	1.450
Unemployment	0.00	~~1.10~~ 1.61
Workers Compensation	0.00	1.20
Other Post Employment Benefits	0.00	14.00

2012-2013 PCCD Holiday Schedule

Date	Holiday
Wednesday, July 04, 2012	Independence Day
Monday, September 03, 2012	Labor Day
Monday, November 12, 2012	Veterans Day
Thursday, November 22, 2012	Thanksgiving Day
Friday, November 23, 2012	Day after Thanksgiving
Monday, December 24, 2012	Christmas Eve
Tuesday, December 25, 2012	Christmas
Wednesday, December 26, 2012	Holiday Closure 1
Thursday, December 27, 2012	Holiday Closure 2
Friday, December 28, 2012	Holiday Closure 3
Monday, December 31, 2012	New Year's Eve
Tuesday, January 01, 2013	New Year's Day
Monday, January 21, 2013	Dr. Martin Luther King, Jr. Day
Friday, February 15, 2013	Lincoln's Birthday Day - observance
Monday, February 18, 2013	Washington's Birthday
Friday, March 29, 2013	César Chávez Day - observance
Monday, May 20, 2013	Malcolm X Birthday - observance
Monday, May 27, 2013	Memorial Day

Any inaccuracies/typos are subject to change

Spring Break 2013 March 25 - March 31, 2013

Medicare—Part D Fact Sheet and Annual Notification

Please review this document carefully.

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

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

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

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

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

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

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

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

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

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

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

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

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

Medicare—Part D Fact Sheet and Annual Notification

Please review this document carefully.

Important Notice from PCCD About Your Prescription Drug Coverage and Medicare

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

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

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

Highlights of the 2012 & 2013 Medicare Prescription Drug benefit:
Minimal monthly premium (varies depending on the plan you choose)

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

Medicare, Kaiser and Caremark Comparison for PCCD Retirees

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

*Co-pays are based on formulary determination and whether or not mail order is used.
*The District reimburses co-pays in accordance prevailing Collective Bargaining Agreements.

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

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

Notification of Pre-Existing Condition Limitation

A group health plan makes coverage effective on the first of the month following your initial date of hire and on each ***open enrollment period*** following. Open enrollment generally occurs in February and August of each calendar for adjunct employees and in May of each year for all other employees.

The District's self-funded plan administered by CoreSource plan imposes a **6-month** maximum pre-existing condition exclusion (18 months for late enrollees) and uses a **6-month** look back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a pre-existing condition exclusion for all eligible participants age 19 and over. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment recommended or received within a **6-month period.** Generally, this **6-month period** ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 6 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the ***6 months*** (18 months if you are late enrollee) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to: **Jennifer Seibert, District Benefits Manager; Peralta Community College District; 333 East 8th Street, Oakland, CA 94606; Phone number: 510.466.7229; Email: jseibert@peralta.edu**

Overage Dependent Status (aka Michelle's Law)

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

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

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

Protected Health Information

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

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duty, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice has been in effect since April 13, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION & EMPLOYEE RIGHTS

Access: You have the right to look at or get copies of your health information, if any exists in any offices, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00, for each page and $15.00, per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions & Complaints: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file you complaint with the U.S. Department of Health and Human Services. Contact: Privacy Officer: Jennifer Seibert 510.466.7229, Address: 333 East 8th Street, Oakland, CA 94606.

GENERAL NOTICE OF COBRA CONTINUATION RIGHTS

Introduction

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

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

COBRA Continuation Coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

www.peralta.pswbenefits.net

GENERAL NOTICE OF COBRA CONTINUATION RIGHTS (continued)

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

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

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

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

California Only: Notice to All Terminating Employees Regarding Medi-Cal & HIV/AIDS
The California Department of Health Services will pay health insurance premiums for certain persons who are losing employment and have a high cost medical condition. In order to qualify for the Health Insurance Premium Payment (HIPP) Program, you must meet ALL of the following conditions:

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

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

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

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

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

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

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

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

www.peralta.pswbenefits.net

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Retiree Information

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

1. Life-time medical insurance at District cost, eligibility is based on hire date, retirement date and/or PCCD union affiliation

2. Reimbursement of Medicare A & B premiums

3. Life insurance continues until age 66, conversion is available at the retiree's expense

4. Membership in the Peralta Retiree Organization

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

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

Plan/ Regulation			
Criteria	**COBRA Regulation** (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 enrolled 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 COBRA (no late entry)
Network	Delta Dental Premier or United Health Care Dental	DeltaCare, a PMI product, limited network	Delta Dental Premier
How to elect?	Complete COBRA election form; make payments	Complete Kaiser Senior Advantage Form	Complete election form; make payments
Group number	938 (Delta Dental) / 04N6328 (UHC)	65	7226
Single	UHC: $27.48 / Delta: $75.78	No additional cost to retiree	$96.53
2 party	UHC: $43.97 / Delta: $128.83		$179.74
3 party	UHC: $67.00 /Delta $197.04		$222.64
Sliding scale benefits?	No	No	Yes Year 1: 70%; Year 2: 80%; Year 3: 90%; Year 4: 100%
Where can you obtain more information?	Combined Evidence of Coverage & Disclosure Form	DeltaCare Dental HMO Program	Carrier Summary
Website location	www.peraltaretirees.pswbenefits.net		www.deltadentalins.com

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

DURATION OF BENEFITS

How long do medical benefits last after retirement?

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

OTHER MEDICAL PLAN FEATURES*

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

**See the Summary Plan Description for specific plan details.*

Post-retirement monthly premium costs are determined by:

- District affiliation
- Medical plan enrollment
- Coverage level

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

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

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

Additional Resources

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

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

FREQUENTLY ASKED QUESTIONS

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

2. Can surviving spouses change benefit plans?
   Yes, the surviving spouse retains the opportunity to change medical plans during the annual open enrollment window.

3. To who are monthly premiums paid?

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

4. What is Benefit Dynamics?
   Benefit Dynamics is the third-party administrator for the District's
   - Medicare Premium Reimbursement Plan
   - COBRA benefits
   - Flexible benefit plans under IRS codes 105, 125 and 132

5. Are survivors eligible for the Medicare A & B reimbursement program?
   Yes, if they coordinate their coverage with a Peralta group plan, pay premiums and provide documentation of the premiums paid, then the survivor continues to be eligible for the program.

6. Are survivors eligible for the Kaiser mail-order reimbursement program?
   Yes, reimbursement will be made on a semi-annual basis for eligible expenses.

7. Does Peralta pay premiums for surviving spouses of Peralta retirees?
   No.

September 2012

Benefits Spotlight

PRE RETIREMENT CHECKLIST

Within 90 days of Retirement-for counseling and guidance:

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

Within 60 days (after retirement)

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

Within 30 days of Retirement

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

POST-RETIREMENT CHECKLIST

Semi-Annually

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

Annually

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

Within 30 days

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

Survivors Checklist

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

CHECK OUT YOUR BENEFITS INFORMATION CENTER (BIC)!

To learn more about your welfare benefits, visit your Benefit Information Center (BIC) website:
www.peralta.pswbenefits.net or www.peraltaretirees.pswbenefits.net

Summary Plan Description Changes for Self-funded Plan
(currently administered by CoreSource) from 2006- 2008

Peralta Community College District Benefits Office

Effective date	2006 SPD Section Entitled	Subsection	Issue addressed by correction or update to the SPD	Reason for Change to the 2006 SPD
07/01/06	Eligibility, Enrolment and Effective Date	Employee Eligibility	• Reconfirms that ownership of the self-funded plan is governed by the employer and not the third-party administrator ; • Incorporates notification language to employees regarding eligibility	• Clarification and compliance
07/01/06	Eligibility, Enrolment and Effective Date	Termination of Employee Coverage	• Prior summary plan descriptions omitted reference to contracted non-California networks (PHCS and Interplan)	• Update reference to reflect current business partners
07/01/06	Coverage for Surviving Dependents	none	• Section added	• Conformity and continuity • Documentation of intent for coverage for surviving dependents

Effective date	2006 SPD Section Entitled	Subsection	Issue addressed by correction or update to the SPD	Reason for Change to the 2006 SPD
02/01/07	Vision Expense Benefit	Vision Expense Benefit: Network Benefits	• Change of claims filing address from Maryland to Utah	• Update to procedure
02/01/07	Summary Plan Description	Union Plans	• Local SEIU changed from 790 to 1021	• Conformity to new name
02/01/07	Summary Plan Description	Union Plans	• Local 30 should be 39;	• Correction
02/01/07	Prudent Buyer Preferred Provider or Non-preferred Provider provision	Preferred Provider	• Generic reference to "preferred provider" v "non-preferred provider" and • Incorporate Private Health Care Systems as a network	• Compliance; • Reconfirmation of network availability to for non-California residents.

Source Documents:
Peralta Community College District Employee Benefit Plan-Plan Document and Summary Plan Description – Effective Date: January 1, 2008 Active and Retired Employees (Post 2004 retirees)

Peralta Community College District Employee Benefit Plan-Plan Document and Summary Plan Description – September 1, 2006 Active and Retired Employees 7-01-04

Summary Plan Description Changes for Self-funded Plan
(currently administered by CoreSource) from 2006- 2008

Peralta Community College District Benefits Office

			for non-California residents	
02/01/07	Prescription Drug Program	Pharmacy Option Co-pay	• Limitations on impotence medication removed; other language within that section is brought into compliance with the intent to cover impotence medication	• Conformity to past practice coverage
02/01/07	Prescription Drug Program	Claims Filing address	• Global changes to named business partners	• Changed from Medco to Caremark ; • Claims filing and other administrative procedures re-aligned accordingly for the new fiduciary, Caremark
02/01/07	Prescription Drug Program	Covered Prescription Drugs; Introduction to Specialty Pharmacy Program with enhanced benefits	• Coverage list expanded	• Conformity to past practice coverage; • Announcement of new added "Specialty Benefits " services offered by new pharmacy fiduciary, Caremark
02/01/07	Medical Expense Benefit	Chiropratic Care	• Allows eligibles to self-refer and receive coverage for non-medically necessary benefits as provided before the change from Blue Cross to CoreSource as third-party administrator change	• Conformity to past practice

Source Documents:
Peralta Community College District Employee Benefit Plan-Plan Document and Summary Plan Description – Effective Date: January 1, 2008 Active and Retired Employees (Post 2004 retirees)

Peralta Community College District Employee Benefit Plan-Plan Document and Summary Plan Description – September 1, 2006 Active and Retired Employees 7-01-04

Summary Plan Description Changes for Self-funded Plan
(currently administered by CoreSource) from 2006- 2008

Peralta Community College District Benefits Office

Effective date	2006 SPD Section Entitled	Subsection	Issue addressed by correction or update to the SPD	Reason for Change to the 2006 SPD
01/01/08	N/a	N/a	• Any and all references to "Prudent Buyer Plan" shall be replaced with "Anthem BC Prudent Buyer Plan"	• Acquisition; global change
01/01/08	Summary Plan Description	Employer Identification Number	• Correction to the Employer Identification Number	• Correction from 941676375 to 941590799
01/01/08	Preferred Provider or Non- Preferred Provider	Exceptions for covered dependents	• Provides in-network coverage for out-of-network dependent	• Conformity with past practice
01/01/08	Plan Exclusions	Reference 18	• New plan language introduced during conversion but was subsequently removed • In the event of multiple coverage, plan language was introduced to allow us to deny claims when our covered member failed to follow other insurance claim filing procedures.	• Language removed to comply with past practice

Prepared September 2012 by the PCCD Benefits Office

Source Documents:
Peralta Community College District Employee Benefit Plan-Plan Document and Summary Plan Description – Effective Date: January 1, 2008 Active and Retired Employees (Post 2004 retirees)

Peralta Community College District Employee Benefit Plan-Plan Document and Summary Plan Description – September 1, 2006 Active and Retired Employees 7-01-04

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

Flexible Benefit Plan Open Enrollment Notice
October 15, 2012

You are receiving this Open Enrollment Notice for the flexible benefits plan established under IRS Tax Code 125 because you are eligible to participate in the Medical Reimbursement Account and/or the Dependent Day Care Reimbursement Account for the next plan year. The next plan year begins January 1, 2013 and ends June 30, 2013-This is a short plan year.

If you **are** currently participating in the plan:
Your current election expires on December 31, 2012. In order to continue contributions into 2013, please complete and return the enclosed Flexible Benefits Plan Enrollment form to the Peralta District Benefits Office by Monday, December 3, 2012. (Do not return the form to Benefit Dynamics).

If you do nothing, then your contributions end with the December 31, 2012 paycheck. IRS regulations permit future re-enrollment if and when there is a qualifying event. (See page 8 -#6 of the enclosed Summary Plan Description-Section entitled "May I change my elections during the plan year."

Also note that the deadline for claiming 2012 expenses is March 31, 2013. Unclaimed contributions are forfeited after that date. Again, see page 11-#2, of the Summary Plan Description-What happens if I don't spend all plan contributions?"

If you **are not** currently participating in the plan:
Then now is the time to consider enrolling!
Enclosed is the Section 125 Flexible Benefits Plan Summary Description that you can use for planning purposes and in order to determine if there is a direct benefit to you.

Want to learn more?
If you want to learn more about the advantages or considerations of participating in the 125/132 Flexible Benefits Plan, or if you have questions, you are encouraged to:

- Ask your personal question of Benefits Dynamics on Thursday, November 15 during the Benefits Fair from 10 – 2 or
- Contact the Benefits Office at 510 466 7229 or Pension Dynamics at 925 956 0514 or PSW Benefits Resources at 877 866 2623.

Special Notes:

1. ***In order to bring our Flexible Benefit Plan into alignment with our medical and dental plans, there will be two enrollment windows:***

Election Window	***Claims Period***
11/1/12-11/30/12	***1/1/13-6/30/13 (6 months)***
5/1/13-5/31/13	***7/1/13-6/30/14 (12 months)***

2. ***Per IRS regulations and in accordance with Health Care Reform, the maximum contribution amount for the calendar year January – December 2013 cannot exceed $2,500 for the Medical Reimburesment Account and $5,000 for the Dependent Care Reimbursement Account***

Enclosures: Employee Flexible Benefits Plan Summary Plan Description
Flexible Benefits Plan Enrollment Form 2013 for Plan Year 1/1/2013 through 06/30/2013

PERALTA COMMUNITY COLLEGE DISTRICT

EMPLOYEE FLEXIBLE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

Pension Dynamics Corporation
2013

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INTRODUCTION

This document is the Summary Plan Description ("SPD") of the Peralta Community College District Flexible Benefit Plan. We have implemented this Plan in order to allow our Employees to choose to use part of their salary to pay the cost of certain Employer-sponsored Benefits with pre-tax dollars. It is intended to provide a summary of the Plan rules and Benefits offered by Peralta Community College District under IRC Section 125.

Please read this document carefully so that you fully understand the provisions of the Plan prior to enrolling as a Participant. If you do not understand any part of this document please consult your Plan Administrator and/or Plan Service Provider for additional clarification. A copy of the formal Plan Document is on file with the Plan Administrator (Peralta Community College District) and is available for your review.

One of the most important features of this Plan is that the Benefits offered are generally ones you are already paying for, but with money that has been subject to taxation. Under this Flexible Benefit Plan, these same Benefits are paid for with a portion of your pay before federal, state and social security taxes are withheld. This means you will pay fewer taxes and have more money to spend and save.

In the event there is a conflict between this Summary Plan Description and the Plan Document, the Plan Document will control. Also, if there is a conflict between an Insurance Contract and either the Plan Document or this Summary Plan Description, the Insurance Contract will control.

I
PLAN IDENTIFICATION

1. Plan Name: Peralta Community College District Flexible Benefit Plan

2. Type of Plan: IRC Section 125 Cafeteria Plan (Flexible Benefit Plan) including:

   (a) Pre-tax Premium Payment
   (b) Medical Expense Reimbursement Account
   (c) Dependent Care Reimbursement Account

3. Plan Administrator: Peralta Community College District

4. Initial Plan Year: March 1, 2004 through December 31st

5. Subsequent Plan Years: January through December (Amended January 1, 2013 for one short Plan Year of 1/1/2013-6/30/2013 and then subsequent Plan Years of July 1 – June 30.)

5. Plan Service Provider: Pension Dynamics Corporation
   2300 Contra Costa Blvd., Suite 400
   Pleasant Hill, CA 94523-3955

6. Source of Contributions: Voluntary Employee Salary Re-Direction

II
ELIGIBILITY

1. WHEN CAN I BECOME A PARTICIPANT IN THE PLAN?

Before you become a "participant" in the Plan, there are rules you must satisfy. First, you must meet the "eligibility requirements". The next step is to join the Plan on the "entry date". You will be required to complete an application form before you can enroll in the Plan.

2. WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR OUR PLAN?

As an active employee you will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan(s).

3. WHEN IS MY ENTRY DATE?

You can join the Plan on the same day you are eligible to join our group medical plan. However, your entry date can not be prior to the date you sign the enrollment form.

4. ARE THERE ANY EMPLOYEES WHO ARE NOT ELIGIBLE?

Yes. Employees who are not eligible to receive medical Benefits under our group medical Plan are not eligible to join the Flexible Benefit Plan.

5. WHAT MUST I DO TO ENROLL IN THE PLAN?

Before you can enroll in the Plan, you must complete an application to participate in the Plan. The application includes your choices for each Benefit offered under the Plan. We also require your authorization to redirect from your paychecks the dollar amount you have elected to fund your Flexible Spending Accounts. New hires will need to complete the application and the authorization within 30 days of becoming eligible to participate. All other Employees will need to complete the enrollment process each year during the month prior to the start of the new Plan Year. It is understood that any Employee who does not complete an enrollment form during the enrollment period does not wish to participate in the Plan for the full Plan Year and will not have an opportunity to enroll until the beginning of the following Plan Year unless they experience a change in family status which qualifies them to change their election(s).

III
OPERATION

1. HOW DOES THIS PLAN OPERATE?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. The portion of your pay that is contributed to the Plan is not subject to federal, state, or social security taxes, thereby allowing you to **use tax-free dollars** to pay for certain kinds of Benefits and expenses which you would normally pay for with out-of-pocket, taxed dollars. However, any reimbursement you receive under this Plan cannot be claimed as a tax credit or deduction on your income tax return.

QUALIFYING MEDICAL CARE EXPENSES

Under our Plan, you will be reimbursed only for medical expenses covered by the plan. These expenses are similar to those normally deductible on your federal income tax return (without regard to the 7.5% of adjusted gross income limitation). They include, for example, expenses you have incurred for:

1. Prescription medications, birth control, and vaccines that your doctor prescribed.
2. Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts.
3. Medical examinations, X-rays, laboratory services, and insulin treatments prescribed by your doctor.
4. Hospital care, clinic costs, and lab fees.
5. Medical treatment at a center for substance abuse.
6. Medical aids such as hearing aids (and batteries), dentures, prescription eyeglasses and/or contact lenses, braces, orthopedic shoes, etc.
7. Ambulance service and other travel costs to get medical care. If you use your own car, you can claim ten cents per mile. In addition, you can claim parking and toll costs.
8. Over-the-counter drugs and medications used for the treatment of a medical condition, injury, or illness. Due to Health Care Reform a prescription will be required prior to reimbursement of over-the-counter drugs and medications as of 1/1/2011.

Please see your Flexible Benefit Plan Employee Handbook for a more comprehensive list of eligible and ineligible expenses. Please be aware that only products and services which are deemed to be *medically necessary* to *treat a diagnosed condition, injury, or disease* will be considered for reimbursement through the Flexible Benefit Plan.

IV
CONTRIBUTIONS

1. HOW MUCH OF MY PAY MAY MY EMPLOYER REDIRECT?

Each year, you may elect to redirect enough of your Compensation to pay for the Benefits that you elect under the Plan. This amount will be deducted from your pay each pay period on a pro rata basis over the course of the year. However, you may not have more than 100% of your Compensation redirected. The maximum amount you may allocate to each of the Flexible Benefit Plan Reimbursement Accounts is as follows:

Medical Expense Reimbursement Account:..... $2500

Dependent Daycare Reimbursement Account..... $5000

2. HOW IS MY COMPENSATION MEASURED UNDER OUR PLAN?

Compensation under our Plan means the total gross amount paid to you by Peralta Community College District each year (including bonuses).

3. WHAT HAPPENS TO CONTRIBUTIONS MADE TO THE PLAN?

Before each Plan Year begins, you will select the Benefits you want and designate the amount of contributions to go toward each Benefit. It is important that you make these choices carefully based upon the anticipated expenses you expect to incur during the Plan Year for each Benefit. Each time you are paid, your salary is reduced by the amount you elected to contribute before federal, state and social security taxes are withheld. Amounts withheld for Insurance Premiums are forwarded to the insurance carriers, amounts withheld for Flexible Spending Accounts will be held in Peralta Community College District's general assets until you submit an eligible claim for reimbursement.

4. WHEN MUST I DECIDE WHICH ACCOUNTS I WANT TO USE?

You are required by Federal law to decide before the Plan Year begins, during the "Election Period".

5. WHEN IS THE "ELECTION PERIOD" FOR OUR PLAN?

When you first meet the "eligibility requirements". Your Election Period will start on that date (referred to as your "entry date"), and continue for thirty days past your "entry date." (You should review Section I on Eligibility to better understand the terms "eligibility requirements" and "entry date.") Then for each following Plan Year, the Election Period is established by the Administrator and uniformly applied to all participants. Normally, it will be a period of approximately 30 days prior to the beginning of each Plan Year. The Administrator will inform you each year regarding the Election Period. (See Section VIII on General Information About Our Plan for the definition of Plan Year.)

6. MAY I CHANGE MY ELECTIONS DURING THE PLAN YEAR?

Generally, no. You cannot change the elections you have made after commencement of the Plan Year. However, there are certain limited situations when you may change your elections. Federal law considers the following examples of a qualified change in family status which may allow you to make a change to your election:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Death of Spouse or dependent
- Event which impacts the eligibility of your dependent(s)
- Unpaid leave of absence by you or your spouse
- Significant change in your employment status/eligibility
- Significant change in Benefits directly attributable to your spouse's employment

There may be other criteria which could be considered a change in family status. However, any change in your Benefit election(s) must be consistent with the change in family status and is subject to approval based on IRS regulations. If you feel you may have a qualified change in status, please contact your Administrator for more information on your specific situation and for the required forms for changing your Benefit elections.

In addition, for health insurance premiums being contributed to the Plan, we will adjust the Salary Redirection Election you have made for the remainder of the Plan Year if there is a change in the premium expense. If the increase in premium expense is significant, we will let you either change the Salary Redirection election to accommodate the increase, or revoke your election entirely.

7. MAY I MAKE NEW ELECTIONS IN FUTURE PLAN YEARS?

Yes, during the Election Period for the new Plan Year, if you meet the eligibility requirements and wish to participate, you must complete a new election form. At this time, you may make new Benefit elections. If you fail to complete an enrollment form for the new Plan Year we will assume you wish your insurance premium deductions to remain as they were for the prior Plan Year. However, we will assume you do not wish to have any additional funds redirected for spending accounts. Spending Account Elections Do Not Automatically Roll Over To The New Plan Year—You Must Sign A New Enrollment Form Each Year.

V
BENEFITS

1. WHICH BENEFITS ARE AVAILABLE?

Under our Plan, you can choose to receive your entire Compensation in cash or use a portion to pay for the following Benefits or expenses during the year:

Premium Expense Account

A Premium Expense Account allows you to use tax-free dollars to pay for certain Premium Expenses under various insurance programs that we offer you. These Premium Expenses may include:

-- Health care premiums under our insured group medical plan

-- Dental insurance premiums under our insured group medical plan

-- Vision insurance premiums under our insured group medical plan

Only insurance plans sponsored by Peralta Community College District can be run through this portion of the Plan and certain limitations of coverage may apply. Individual policies, policies through a spouse's Employer, and COBRA payments can not be processed on a pre-tax basis.

The Administrator may terminate or modify Plan Benefits at any time, subject to the provisions of any Insurance Contracts providing the Benefits described above. We will not be liable should an insurance company fail to provide any of the Benefits described above, even if the failure to provide Benefits is due to our negligence or gross neglect (for example, if we fail to enroll you or pay premiums). Also, your insurance coverage will end when you leave employment or are no longer eligible under the terms of the insurance policies.

Any Benefits to be provided by insurance coverage will be available only after you have submitted to the Administrator the necessary information to apply for insurance, and the insurance is in effect for you.

Medical Expense Reimbursement Account

The Medical Reimbursement Account enables you to pay for expenses that are not covered by our insured medical plan(s) with pre-tax dollars. This account allows you to be reimbursed for out-of-pocket medical, dental, and vision expenses incurred by you, your spouse, and your dependents. The expenses which qualify are those permitted by Section 213(d) of the Internal Revenue Code. A list of covered expenses is available from the Administrator and in your Flexible Benefit Plan Employee Handbook. You may not, however, be reimbursed for the cost of health care coverage maintained outside of the Plan.

In order to be reimbursed for a medical expense, you must submit a request for reimbursement form along with supporting documentation from the provider of service. Reimbursement from the Plan shall be paid at least once a month, typically within one week of your submission of a completed request. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return.

Dependent Daycare Reimbursement Account

The Dependent Daycare Reimbursement Account enables you to pay for out-of-pocket, work-related dependent daycare cost with pre-tax dollars. If you are married or a single parent, the account can be used if you and your Spouse both work or, in some situations, if you or your Spouse attends full-time school.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 - Credit for Child and Dependent Care Expenses. Dependents must be under age thirteen or be physically or mentally unable to care for themselves. Dependent care arrangements which qualify include:

-- Day Care Center, provided that if the facility cares for more than six individuals, the facility complies with applicable state and local laws.

-- An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible.

-- An "Individual" who provides care inside or outside your home. The "Individual" may not be anyone you claim as a dependent for federal tax purposes and must be at least nineteen years of age.

You should make sure that the dependent care expenses you are currently paying qualify under our Plan for reimbursement. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Daycare Reimbursement Account. Also, in order to be reimbursed from this account, you must provide a statement from the service provider giving the name of the provider, the taxpayer identification number or social security number of the provider, the dates services were provided, and the amount of such expense incurred. If your dependent does not live with you for the entire year, you may only submit daycare claims for dates of service during which he/she was residing with you.

As a Participant in the Daycare Reimbursement Account you cannot use the Federal Tax credit for dependent care expenses that have been reimbursed to you through the Plan. If you are not a Participant in the Daycare Reimbursement Account, Federal tax law permits a tax credit for certain dependent care expenses. You may wish to ask your tax adviser which method would better Benefit your personal situation.

The Administrator may terminate or modify Plan Benefits at any time, subject to the provisions of any Insurance Contracts providing the Benefits described above. We will not be liable should an insurance company fail to provide any of the Benefits described above, even if the failure to provide Benefits is due to our negligence or gross neglect (for example, if we fail to enroll you or pay premiums). Also, your insurance coverage will end when you leave employment or are no longer eligible under the terms of the insurance policies.

Any Benefits to be provided by insurance coverage will be available only after you have submitted to the Administrator the necessary information to apply for insurance, and the insurance is in effect for you.

VI
BENEFIT PAYMENTS

1. WHEN WILL I RECEIVE PAYMENTS FROM MY ACCOUNTS?

Insured Benefits:

Requests for payment of insured Benefits should be made directly to the Insurer. The provisions of the insurance policies will control which Benefits will be paid and when they will be paid.

Medical Reimbursement Account

During the course of the Plan Year you may submit requests for reimbursement, of expenses you have incurred, as often as you wish. Expenses are considered "incurred" when the service is performed, not when it is paid for. The Administrator will provide you with the forms for submitting requests for reimbursement. If the request qualifies as a Benefit or expense that the Plan has agreed to pay for, you will receive reimbursement soon thereafter.

Dependent Daycare Reimbursement Account

During the course of the Plan Year you may submit requests for reimbursement of expenses you have incurred as often as you wish. The Plan can not reimburse services that have not occurred yet (i.e. if you pay for April daycare services in March, your reimbursement can not be processed until April). The dependent care account will only reimburse expenses to the extent that there are sufficient funds in the your account to cover your request.

2. WHAT HAPPENS IF I DON'T SPEND ALL PLAN CONTRIBUTIONS?

Any monies left in your accounts at the end of the Plan Year will be forfeited. Of course, qualifying expenses that you incur late in the Plan Year, and request reimbursement for, will be paid prior to any forfeiture. However, you must make your requests for reimbursement no later than ninety days after the end of the Plan Year and services must have been provided to you during your period of eligibility and within the Plan Year.

3. WHAT HAPPENS IF I TERMINATE EMPLOYMENT?

If you leave your employment during the Plan Year, your right to Benefits will be determined in the following manner:

-- You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment. You may elect to COBRA insurance Benefits on an after-tax basis, please see your Administrator for details.

-- You may elect to continue your participation in the Medical Expense Reimbursement Plan for the remainder of the Plan Year (COBRA). If you elect to do so you must continue to make your per pay period contributions on an after-tax basis. If you elect not to continue, participation will cease and no further contributions will be made on your behalf.

-- You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance available in your dependent care account at the time of termination of employment. No further contributions will be made on your behalf after you terminate.

If your participation ceases, you will still be able to submit claims for medical expenses incurred prior to your date of termination. Any monies remaining in the account after termination and for which no eligible expense has been incurred and submitted for reimbursement from the account will be forfeited.

Under Federal law, you, may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if you terminate employment.

If you would otherwise lose your health plan coverage under this Plan because of a termination of employment or reduction in hours, you may continue the health coverage provided under this Plan. However, this will not be a tax-deductible expense to you absent unusual circumstances.

It is your responsibility to notify the Plan Administrator of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the Plan, within sixty (60) days of the event. It is our responsibility to notify the Plan Service Providers of your death, termination of employment, reduction in hours, or Medicare eligibility.

4. WILL MY SOCIAL SECURITY BENEFITS BE AFFECTED?

Your social security Benefits may be slightly reduced because when you receive tax-free Benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution of Social Security on your behalf.

Although the Benefits of this Plan (using tax-free dollars to pay for your expenses) often outweigh the reduction of social security Benefits, we suggest you consult your tax advisor as to the method most suited to your situation.

VII
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. DO LIMITATIONS APPLY TO HIGHLY COMPENSATED/KEY EMPLOYEES?

Under the Internal Revenue Code, "Highly Compensated Employees" and "Key Employees" generally are participants who are officers, shareholders, or highly paid as defined by the IRS. You will be notified by the Administrator each Plan Year whether you are a "Highly Compensated Employee" or a "Key Employee".

If you are within these categories, the amount of contributions and Benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a Plan will be considered to unfairly favor the Key Employees if they, as a group, receive more than 25% of all of the nontaxable Benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on "Highly Compensated Employees" or "Key Employees" will apply. You will be notified of these limitations if you are affected.

VIII
PLAN ACCOUNTING

1. PERIODIC STATEMENTS

Periodically during the Plan Year, the Administrator will provide you with a statement showing your account balance(s). Please read these statements carefully and make a note of the remaining balance(s). Remember, you will want to spend all the money you have designated for a particular Benefit by the end of the Plan Year to avoid forfeiture.

IX
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains general information that you may need to know about the Plan.

1. GENERAL PLAN INFORMATION:

Peralta Community College District Employee Flexible Benefit Plan is the name of our Plan. We have assigned Number 502 to the Plan. The provisions of our Plan become effective on March 1, 2004. Our Plan's records are maintained on a twelve-month period that is known as the Plan Year. The initial Plan Year begins March 1, 2004 and ends December 31st . Each subsequent Plan Year begins on January 1st and ends on December 31st . This has been amended effective January 1, 2013 to include one short plan year of January 1, 2013-June 30, 2013 and then subsequent plan years of July 1 through June 30.

2. EMPLOYER INFORMATION:

The Employer's name and address is:

Peralta Community College District
333 East 8th Street
Oakland, CA 94606

Tax ID#: 94-1676375

3. PLAN ADMINISTRATOR INFORMATION:

The name and address of your Plan's Administrator is:

Peralta Community College District
333 East 8th Street
Oakland, CA 94606

Tax ID#: 94-1676375

The Administrator keeps the records for the Plan and will also answer any questions you may have about our Plan. Please contact the Administrator for any further information about the Plan.

4. SERVICE OF LEGAL PROCESS:

The name and address of the Plan's agent for service of legal process is:

Peralta Community College District
333 East 8th Street
Oakland, CA 94606

5. TYPE OF ADMINISTRATION

It is understood that Peralta Community College District, as the sponsoring Employer, is the Administrator of the Plan. The Administrator shall appoint an individual and/or committee to be responsible for all administrative tasks related to The Plan and to ensure that they are carried out according to the regulations set forth by the IRS, and for the exclusive Benefit of the Employees entitled to participate in the Plan.

Any decisions related to The Plan made by the Administrator will be done in a uniform and nondiscriminatory fashion that is in accordance with the guidelines and regulations set forth by the IRS.

6. PLAN SERVICE PROVIDER :

The Administrator has appointed the following Plan Service Provider to assist and advise in the administration of The Plan in accordance with all governing laws and regulations.

Pension Dynamics Corporation
2300 Contra Costa Blvd., Suite 400
Pleasant Hill, CA 93423-3955

Flex@PensionDynamics.Com

X
ADDITIONAL PLAN INFORMATION

1. YOUR RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Plan participants, Eligible Employees and all other Employees of the Employer are entitled to certain rights and protections under ERISA and the Internal Revenue Code. These laws provide that participants, Eligible Employees and all other Employees are entitled to

(a) Examine, without charge, at the Administrator's office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; and

(b) Obtain copies of all Plan documents and other Plan information upon request to the Administrator. The Administrator may make a reasonable charge for the copies.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants.

No one, including your Employer or any other person, may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a Benefit or exercising your rights under ERISA.

If your request for reimbursement of a claim under the Flexible Spending Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your request for reimbursement reviewed and reconsidered.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to $100 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If your request for reimbursement of a claim is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if your claim is found to be frivolous.

2. CLAIM PROCESS

You should submit your requests for claim reimbursement during the Plan Year, but in no event later than 90 days after the end of a Plan Year. Any claims submitted after that time will not be considered unless a third party (such as an insurance company) is responsible for the delay in paying their portion of a claim. In such circumstances special arrangements must be made with the Plan Administrator prior to the cut-off date. Claim reimbursements for Benefits that are insured will be reviewed in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Plan Service Provider.

If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If we fail to respond within 90 days, your claim is treated as denied. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the application to the Administrator.

Any request for reconsideration of the application should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate Plan provisions. Decisions of the Administrator are conclusive and binding.

X
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our Flexible Benefit Plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

It's Open Enrollment time for the
Flexible Benefits Plan (125 Plan)
Attend the Benefits Fair
Thursday, November 15, 2012
10am-2pm
in the District Office Atrium
Come to the Fair and learn about other
***voluntary benefits** sponsored by Peralta*

Invited Guests:
Benefit Dynamics
Administrator of the District's COBRA plan, Medicare Reimbursement Plans and the 125 Plans-If you are eligible and plan to enroll 125 Plan for Medical and/or Dependent Care expenses in 2013, then the Flexible Benefits Enrollment form for January 1-2013, - June 30, 2013 is due to the Peralta Benefits Office ***Friday, November 30, 2012.***

Athletic Clubs-come here about membership specials:
24 Hour Fitness
Club One-Downtown Oakland
Mariner Square Athletics-Alameda
Kaiser-Wellness Coaches –Did you know Kaiser offered them?!
Financial Services & Consumer Services or Discounts:
Chase Bank
1st United Credit Union
Long-Term Care Insurance through John Hancock
AFLAC, Colonial, & other financial planners
Other Special Guests:
Golden State Warriors—Hear about employee discounts for this season
COSTCO-conveniently renew your membership on-site
Workshops Sponsored by:
Citibank-at-work, ZUK Financial Planning Services, Managed Health Network

Topic	Time	Sponsor
Estate Planning	**10:00-11:00**	**Citibank**
Identity Theft	**11:00-12:00**	**Citibank**
How to Choose a personal financial planner– How does the tax-deferred option meet your objectives	**12:00-1:00**	**ZUK Financial Planners**
Issues Elder Care	**1:00-2:00**	**Managed Health Networks**

Sponsored by the Peralta District Benefits Office

MERCER Key Elements of Health Reform for Employers

- Change in tax treatment for over-age dependent coverage
- Accounting impact of change in Medicare retiree drug subsidy tax treatment
- Early retiree medical reinsurance
- Medicare prescription drug "donut hole" beneficiary rebate
- Break time/private room for nursing moms

- Employers to distribute uniform summary of benefits and coverage (SBC) to participants (deadlines vary with group of recipients)
- 60-day advance notice of mid-year material modifications to SBC content
- Form W-2 reporting for health coverage (track in 2012 for W-2 form provided in early 2013)[4]
- Coverage for additional women's preventive care services begins (plan years on or after August 1, 2012)

- Health insurance exchanges
- Individual coverage mandate
- Financial assistance for exchange coverage of lower-income individuals
- States may expand Medicaid
- HIPAA wellness limit
- Employer shared responsibility
- Additional reporting and disclosure
- Dependent coverage to age 26 for any covered employee's child[2]
- No annual dollar limits[2]
- No pre-existing condition limits[2]
- No waiting period over 90 days[2]
- Additional standards for new or "non-grandfathered" health plans, including limited cost-sharing and deductibles ((\$6,250/individual, \$12,500 /family in 2013) and perhaps limit deductibles to \$2,000/individual, \$4,000/family), provider nondiscrimination, and cover routine medical costs of clinical trial participants
- Health insurance industry fees begin
- Temporary reinsurance fees
- Auto enrollment some time after 2014[3]

- Dependent coverage to 26 (grandfathered plans may limit to children without access to other employer coverage, other than parent's coverage)[1]
- No lifetime dollar limits[1]
- Restricted annual dollar limits, phased amounts until 2014[1]
- No pre-existing condition limitations for enrollees up to age 19[1] and no rescissions[1]
- No health FSA/HRA/HSA reimbursement for non-prescribed drugs
- Increased penalties for non-qualified HSA distributions

- Additional standards for new or "non-grandfathered" health plans, including preventive care in network with no cost-sharing, appeal and external review, provider choice, and non-discrimination rules for insured plans[3]
- Income-based Medicare Part D premiums
- Pharmaceutical importers and manufacturers' fees start
- Medicare, Medicare Advantage benefit and payment reforms to begin
- Insurers subject to medical loss ratio rules

- \$2,500 per plan year health FSA contribution cap (plan years on or after January 1, 2013)
- Comparative effectiveness group health plan fees begin
- Annual dollar limits on essential health benefits cannot be lower than \$2 million
- Employers notify employees about exchanges
- Medical device manufacturers' fees start
- Higher Medicare payroll tax on wages exceeding \$200,000/ individual; \$250,000/couples
- Change in Medicare retiree drug subsidy tax treatment takes effect
- Exchanges initial open enrollment period to begin

- 40% excise tax on "high cost" or Cadillac coverage

1. Applies to all plans, including "grandfathered" plans, effective for plan years beginning on or after Sept. 23, 2010 (Jan. 1, 2011, for calendar year plans).

2. Applies to all plans, including grandfathered plans, effective for plan years beginning on or after Jan. 1, 2014.

3. Delayed until regulations issued/date TBD

4. A temporary exemption applies to certain categories of employers.

exeptions.

08 July 2012