Important Changes to Health Care Options Becoming Effective July 1, 2012

Introduction of the New PPO "Lite" Plan
Introduction of Employee Cost-Sharing for Medical Plans
Increase to Cash-In-Lieu Benefits

Medical Plans Highlights

Effective July 1, 2012

There will be three proposed medical plan options. Two medical plan options will require a monthly contribution from the employee. Kaiser remains the free option to employees at all coverage levels.

1. To continue coverage under the PPO “Traditional” Plan that offers in-network and out-of-network benefits through the Anthem Blue Cross Network, the monthly employee share is based on the union affiliation.

2. We are introducing a third medical benefit plan called PPO "Lite" (PPO = Preferred Provider Organization.) Currently, we are affiliated with Anthem Blue Cross.) The new plan will provide exclusive in-network benefits using the Anthem Blue Cross Network. The employee monthly share will range from $15-$45/month. The in-network benefits of the PPO “Lite” Plan are the same as in the in-network benefits of the PPO “Traditional” Plan.

3. The maximum cash-in-lieu benefit becomes $250/month. Prior to July 1, 2012 the cash-in-lieu benefit is $30/month. *Eligible employees who participate in the cash-in-lieu benefits due to existing group coverage elsewhere will be eligible for:

   $225/month added to their income for cash-in-lieu of medical benefits and
   $25/month added to their income for cash-in-lieu of dental benefits

*Eligibility is based on union affiliation or other negotiated agreement.

In the past, open enrollment was held in October for January changes. Because our benefit plans are now in alignment with the fiscal year, the open enrollment period will now be in the month of May. For 2012, the window will be May 1 - May 31. Now that there are three medical plan options, all benefit-eligible employees are required to re-enroll in the benefit plan of their choice. Due to the complexity of the proposed changes, we will host informational workshops throughout the District.

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<td>Merritt District</td>
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<td>May 10th</td>
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Our objective is to issue new cards by June 20, 2012. To make this happen, the following timeline applies:

- Mailing from the District to employees’ home online access beginning: April 25
- Re-enrollment forms due: May 31
- Reissued cards in employee hands: July 1
- First payroll deduction, if applicable: July 31

What can you expect after July 1, 2012?

Claims and services will be paid according to new provisions based on your selection.

Frequently Asked Questions You Can Use Inside:
- Differences and similarities between PPO “Traditional” and the New PPO "Lite" Plan
- Timeframe of Open Enrollment
- Glossary of Terms
- Qualifying Events and Adding Dependents
- Paycheck Issues and Customer Service for Claims Issues
Frequently Asked Questions—Peralta PPO “Traditional” & Peralta PPO “Lite"

Q1:  When I started, the District only offered two medical plan options. I know a little about Kaiser and a little about our CoreSource Plan. Currently, I already have CoreSource but have had Kaiser in my past as well. What’s this about a new plan?

A:  Our self-funded plan has commonly been referred to as “CoreSource.” In this arrangement, employees primarily use the Anthem Blue Cross Network of providers. Anthem Blue Cross Network is a Preferred Provider Organization (PPO). The District pays the PPO through CoreSource, our third party administrator. The District also pays benefits for eligible services received outside of this network.

Effective July 1, 2012, the District is introducing a plan where covered benefits are only paid for providers contracting inside of the network. This new plan is called PPO “Lite” and currently uses the Anthem Blue Cross Network and the Private Health Care Systems Network for the non-California employee/retiree. Access to coverage in- and out-of the network is still available, at additional cost, to you if you enroll in the PPO “Traditional” Plan.

PPO "Lite" Plan:
Covers benefits using contracted Preferred Provider Organization (PPO) providers only (unless emergency treatment is required—see FAQ 13 and the Glossary of Terms and/or the current Summary Plan Description for current definitions).

PPO “Traditional” Plan:
Covers benefits for service provided both inside and outside of the PPO network.

Q2.  Wasn’t there a monthly cost for the PPO Plan before?

A:  No. Prior to July 1, 2012, employees enrolled in the PPO “Traditional” Plan had access to out-of-network benefits without a monthly premium being deducted from their monthly Peralta earnings. Out-of-network benefits were covered at 80%. In order to retain access to out-of-network benefits, there is now a monthly cost. As in the past, out-of-network benefits will be paid at 80% for covered expenses under the PPO “Traditional” Plan.

If an employee (or eligible enrolled dependent) is currently using an out-of-network provider and intends to continue using the provider after July 1, 2012, then the following options apply:

• Enroll in the PPO “Traditional” Plan
• AND pay the monthly premium
• AND the additional 20% cost for receiving out-of-network services. The 20% is usually paid from the patient directly to the provider of service.

Q3.  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
Q4: I am mid-treatment and am using an out-of-network provider and do not want to change providers. What are my options?
A: You can elect to enroll in the PPO “Traditional” Plan and pay the monthly premium. If you are willing to change providers, then you may ask your provider for a referral within the PPO. You may also consider enrolling in the Kaiser HMO Plan.

Q5: 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 3).

Q6: If I am already on the District’s PPO “Traditional” Plan currently administered by CoreSource, and choose to enroll in the PPO "Lite" Plan, then what happens to my deductible?
A: If you have already met your calendar year deductible, you will not have to meet it again this 2012 calendar year.

Q7: I currently use a provider who is part of the Anthem Blue Cross Network for eligible services. If I return in six months for another visit, should I reconfirm that the provider is in the network? After all, the provider has a copy of my insurance card showing my coverage. Does the provider have an obligation to let me know of the change, or do I need to verify that each doctor, facility or service appointment is part of the Anthem Blue Cross network each time I utilize a service?
A: You are responsible for ensuring that the provider you are seeing each and every visit is a contracted provider as outlined above. You are also encouraged to have your provider pre-authorize service through the toll free number noted on your current enrollment card. The pre-authorization numbers are not changing in this process (See FAQ 3).

Q8: If I have a dependent out-of-state AND I enroll in PPO "Lite", then how does the Peralta PPO "Lite" coverage change things? There is no network in my dependent’s area?
A: From July 1, 2012—June 30, 2013 eligible benefits will be paid as in-network. Thereafter, coverage will only be available for emergency services only. Peralta is looking for expansive networks out of California during the first term of the agreement.

Q9: What happens if someone on Kaiser is in this same situation as stated above?
A: If someone has a dependent out of state or outside of the Kaiser service area, the child would have access to emergency services only (See Glossary for Emergency Definition).
Frequently Asked Questions—Peralta PPO “Traditional” & Peralta PPO "Lite"

Q10: **How does the Peralta PPO "Lite" Plan change things for retirees who move to other states or rural areas of California where there may be no access or limited access to the Anthem Blue Cross network?**
A: The same rules currently in place will continue to apply. If an employee/retiree as of July 1, 2012:
   - resides in California, then the employee/retiree would be covered under Anthem Blue Cross;
   - Retirees who elect the PPO Lite plan:
     - Year 1: Status quo for people who retire and move out of California
     - Year 2 & 3: Revisit out-of-state networks
The parties will examine the adequacy of the PPO network of out-of-state providers of the PPO Lite plan for retirees who move out of state after July 1, 2013.

Q11: **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.

Q12: **Do I pay for PPO "Lite" when I retire?**
A: No

Q13: **What constitutes an emergency irrespective of a member’s participation in PPO “Lite”, PPO “Traditional” or Kaiser?**
A: Below is the Peralta Plan description of a “true emergency”

**Emergency**

An accidental **injury**, or the sudden onset of an **illness** where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:
1. Placing the **covered person’s** life in jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or
4. Causing serious dysfunction of any bodily organ or part.
Q14: I have heard that annual open enrollment is now occurring in May for July 1, 2012 effective dates. Is that true?
A: Yes, all benefit-eligible employees on record as of March 31, 2012 will be sent information about re-enrollment into benefits. Open enrollment is the annual opportunity to change plans and add eligible dependents to group insurance.

Q15: What happens if I do nothing?
A: If you do nothing, meaning, that you do not re-enroll by May 31, 2012, then the default reenrollment processes will apply. This means that your current enrollment will default to Kaiser coverage because:
- There is no employee contribution for Kaiser.
- We cannot enroll you into a plan which requires a monthly contribution without your expressed election.
- Please note that our open enrollment is being serviced by CoreSource and they will process enrollment changes on our behalf. The Open enrollment Announcement will be sent to your home address of record during the last week of April.

Q16: Will there be Open Enrollment in November?
A: No. Our open enrollment period is now in alignment with the fiscal year rather than the calendar year.

Q17: Cash-in-lieu of benefits—What are they?
A: Effective July 1, 2012, District 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.

Q18: 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.
Q19: Because our plan features are changing and co-pays may be increasing, can I enroll in the flexible benefits plan under tax code 125?
A: No. Under the applicable tax-code and because our flexible benefits plan runs on a calendar year, there is no qualifying event which would allow an employee to increase or decrease their contribution at this time.

Q20: 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.

Q20: 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.

Q21: 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).
Q23: What if there is an error on my July 31, 2012 paycheck?
A: From time-to-time paycheck deductions are incorrect, currently, when matters are brought to the attention of the Benefits Office, we log the customer service issue and track the issue to closure.

Q24: What if I don’t get a paycheck for a month—I don’t receive a check in July for example?
A: We are exploring maximizing the payroll function in our current PeopleSoft System so that the system will automatically recover missed premiums on the next pay cycle.

Q25: 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.

Q26: 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.

Q27: Domestic Partners & Imputed Income—If I add a domestic partner to the coverage, how is my paycheck affected?
A: You can add a domestic partner to your medical and dental insurance. However, the IRS requires that you be taxed on the value of the premium attributable to the domestic partner. In other words, your gross taxable income is increased by the amount of the insurance premium paid on behalf of the domestic partner. Still confusing? Here is an example of imputed income for an employee coverage of a domestic partner on the Kaiser HMO plan:

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Q28: 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
**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.