2024-2025 CONTRA COSTA COMMUNITY COLLEGE DISTRICT RETIREE BENEFITS

LIVE WELL. BE HAPPY.

Contra Costa Community College District

pathways to success

CONTENTS

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

GETTING STARTED

2024-2025 BENEFITS

July 1, 2024
through
June 30, 2025

At Contra Costa Community College District (CCCCD), we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason the District offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here.

Need more information?

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, you can refer to your plan summaries or summary plan descriptions (SPDs), which can be accessed at 4cd.edu/hr/benefits.

WHO'S ELIGIBLE FOR BENEFITS?

Who is eligible?

In general, employees who have met requirements for retiree benefits are eligible for the plans noted on this guide.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Your children (including your domestic partner's children):
  - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
  - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.
  - Court-ordered legal guardian.

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

Who is not eligible?

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

- Parents, grandparents, and siblings.
- Employees who were not hired as permanent, temporary employees, contract employees, or employees residing outside the United States.

When you can enroll

Coverage commences the first of the month following date of retirement.

Open enrollment is generally held October-November. Open enrollment is the one time each year you can make changes to their benefit elections without a qualifying life event.

Employees are strongly encouraged to enroll in Medicare Part B three months prior to retirement (if eligible). Employees must be enrolled in Medicare Part B to be eligible for District sponsored Medicare plan.

Retirees enrolled in a District-sponsored Medicare plan may be eligible for reimbursement of Medicare Part B premium for the previous calendar year.

Employees who turn 65 years of age may defer enrollment in Medicare Part B until retirement. Employees in this situation must consult with the Social Security Administration office. Enrollment into Medicare Part A & B is conducted through the Social Security Administration office and not through the District.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

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

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

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

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

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

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

MEDICAL

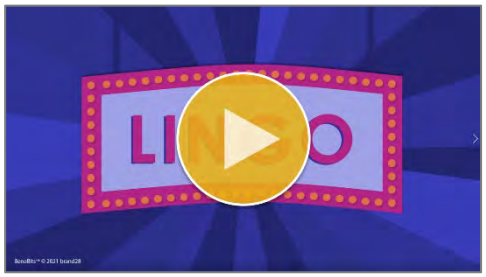
OUR PLANS

Anthem Medicare Preferred PPO with Senior Rx Plus

Kaiser Permanente Senior Advantage HMO

All About Medical Plans

Play the Health Lingo Game!



We offer 2 medical plans through Anthem Blue Cross and Kaiser Permanente.

- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **OUT-OF-POCKET MAXIMUM:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.

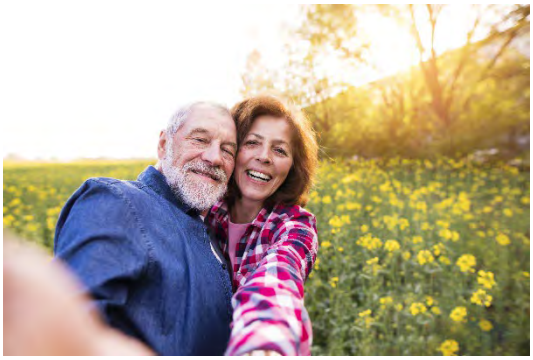
Medical

You always pay the deductible and copayment ($).

	Anthem Medicare Preferred PPO with Senior Rx Plus		Kaiser Permanente Senior Advantage HMO
	In-Network	**Out-of-Network**	**In-Network Only**
Calendar Year Deductible Individual Family	$0 $0		$0 $0
Calendar Year Out-of-Pocket Maximum[1,2] Individual Family	$1,500 per individual No family maximum		$1,000 per individual No family maximum
Office Visit Primary Care or Specialist	$15 copay	$15 copay	$5 copay
Preventive Services	No charge	No charge	No charge
Chiropractic/Manipulation	$15 copay (limited to Medicare covered visits)	$15 copay (limited to Medicare covered visits)	$5 copay
Lab and X-ray	Lab work: No charge X-ray: $15 copay	Lab work: No charge X-ray: $15 copay	No charge
Urgent Care	$15 copay	$15 copay	$5 copay
Emergency Room	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$50 copay (waived if admitted)
Inpatient Hospitalization	$100 per admission	$100 per admission	$100 copay
Outpatient Surgery	No charge	No charge	$5 copay
PRESCRIPTION DRUGS			
Annual Deductible	None		None
Out-of-Pocket Maximum	Combined with medical		Combined with medical
Retail Tier 1 - Generic Tier 2 - Preferred Brand Tier 3 - Non-Preferred Brand Supply Limit	 $5 copay $15 copay $15 copay 30 days	 $5 copay $15 copay $15 copay 30 days	 $5 copay $5 copay Not covered 100 days
Mail Order Tier 1 - Generic Tier 2 - Preferred Brand Tier 3 - Non-Preferred Brand Supply Limit	 $10 copay $30 copay $30 copay 90 days	 $10 copay $30 copay $30 copay 90 days	 $5 copay $5 copay Not covered 100 days

[1]Out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

ANTHEM RESOURCES



SYDNEY MOBILE APP

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

Livehealth Online

LiveHealth Online is your telemedicine vendor and lets you have a video visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. Doctors are available 24/7/365 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy. Register online at livehealthonline.com and make sure to download the mobile app.

24/7 Nurse Line

24/7 NurseLine serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care. For help, call 24/7 NurseLine at 800-337-4770.

Diabetes Prevention Program

This 12-month weight loss program can help you lose weight and reduce your risk of diabetes. Anthem and Lark come together to offer this program at no extra. It is a part of your health plan. Receive a free smart scale. To see if you, quality, go to enroll.lark.com/anthem

Special Offers

Visit www.anthem.com/ca, choose Care, and select Discounts to save money on glasses, weight loss programs, gym memberships, and vitamins.

Foreign travel emergency and urgently needed services:

Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition. Emergency outpatient care Urgently needed services Inpatient care (60 days per lifetime) This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/ received in the United States. If you are in need of emergency care outside of the United States or its territories, you should call the Blue Cross Blue Shield Global Core Program at 800-810-BLUE or collect at 804-673-1177. Representatives are available 24 hours a day, seven days a week, 365 days a year to assist you. When you are outside the United States or its territories, this plan provides coverage for emergency/urgent services only. This is a Supplemental Benefit and not a benefit covered under the federal Medicare program. For more coverage, you may have the option of purchasing additional travel insurance through an authorized agency.

ANTHEM RESOURCES CONT.

Medicare Community Resource Support (MCRS)

The Medicare Community Resource Support benefit is designed to help members bridge the gap between their medical needs/benefits and the resources available within their community. MCRS is an outbound, telephone-based team staffed by social workers who leverage local community programs, services, and supports available in the member's specific market/region to address Social Drivers of Health, increase community connectedness, and improve overall health equity.

This benefit links members to community resources such as:

- Transportation (medical/non-medical)
- Food pantries
- Home weatherization programs
- Utility assistance programs
- Co-pay assistance programs
- Social activities
- Help around the home (HHA/PHH)
- DME Resources
- Housing Resources (financial/HUD housing vouchers)
- Dental (Sliding scale clinics)

Call the phone number on the back of your ID card for assistance.

House Call Program

More time to talk about your health. More information to help doctors provide care and treatment. The idea behind Anthem's House Call program is for a licensed House Call clinician to come to your home to complete the evaluation. You can also meet with the clinician virtually on your computer, tablet, or smartphone. During these house calls, the goal is to complete a health and wellness assessment. Reviewing blood pressure, medication, health-related questions, and follow-up appointments as needed. The House Call program is available at no additional cost. Your personalized health assessment includes:

- A health and wellness survey.
- Height, weight, and blood pressure measurements.
- Time to discuss your health-related questions and concerns.
- A review of your medications.
- Help schedule follow-up appointments if needed

Healthy Meals Benefit

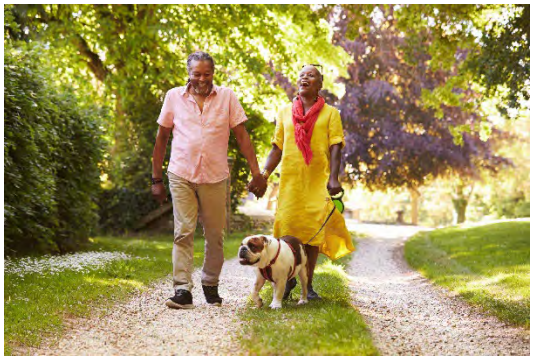
Meal delivery services are available for inpatient discharges and health-related issues.

- This benefit provides healthy meals to a member upon a qualifying event, includes when you are in a hospital or a skilled nursing facility and are discharged home
- Meals may also be used to improve the health of our members with a Body Mass Index (BMI) of 18.5 or under, a BMI of 25 or higher, or an A1C level of more than 9.0 as determined by their provider.
- This benefit also qualifies as a Special Supplemental Benefit for the Chronically Ill (SSBCI). To receive meals as a Special Supplemental Benefit for the Chronically Ill, you must Meet the CMS-mandated criteria, which may include providing supporting information from you or, at times, your physician.
- The Healthy Meals benefit offers up to 56 meals a year. The member can receive 14 meals (two meals for seven days) with up to four separate events (inpatient stay or chronic meal event recertification).

Member Connect

This program is designed to engage members identified as being socially isolated or lonely by providing them with a phone pal. These phone pals are trained Anthem volunteers from across the organization who serve as a support person to the member and can also connects the member to relevant clinical programs. Call the phone number on the back of your ID card for assistance.

KAISER RESOURCES



FIND A KAISER PROVIDER

We know how important it is to find a doctor who's right for you. Browse our online doctor profiles to see your options at kp.org/searchdoctors or call 1-800-464-4000.

kp.org AND KAISER APP

Stay engaged with your health and manage your care and your family's right at your fingertips anytime, anywhere in one convenient place on the Kaiser Permanente website or download the Kaiser Permanente app from the Apps Store or Google Play.

24/7 Advice Line

Get on-demand support with 24/7 care advice by phone from a Kaiser Permanente provider at 1-866-454-8855.

Email, Phone and Video Appointments, E-visits

Get convenient access to care. Email your doctor's office with non-urgent questions, talk to a Kaiser Permanente healthcare professional over the phone or by video, or use our online questionnaire to get self-care advice with an online E-visit. Sign on to kp.org or use our mobile app.

My Doctor Online App (for No. CA members)

My Doctor Online offers timely updates about your care, ways to stay in touch with your doctors, the ability to manage your specialty and other appointments, and other personalized tools to keep you healthy and connected.

Download our mobile app today on a smartphone or tablet at App Store or Google Play.

Active&Fit Direct

Fitness made easy and affordable. The fitness program allows you to choose from 12,500+ participating gyms and YMCAs nationwide for $28 a month (plus a $28 enrollment fee and applicable taxes). To enroll, visit kp.org/exercise.

Traveling?

Rest assured you're covered when traveling. Members are covered for emergency and urgent care anywhere in the world. How you get care can vary depending on where you are. For more information, visit kp.org/travel or call the

Travel Line at 1-951-268-3900.

Calm App

The number one app for meditation and sleep. Choose from hundreds of programs and activities including guided meditations, music, mindful movement, and sleep stories to help lower stress, reduce anxiety, and improve sleep quality. Available to members 13 years and over and no referral needed. Visit kp.org/selfcareapps to get started.

Headspace Care App

Offers one-on-one emotional support coaching and self-care activities anytime, anywhere to help with many common challenges. Coaches are available by text 24/7 and no referral needed. Available to members 18 years and over. Visit kp.org/selfcareapps to get started.

FITNESS PROGRAMS

ADDITIONAL INFORMATION REGARDING FITNESS PROGRAMS

- Anthem Members: silversneakers.com/starthere
- Kaiser Members: silverandfit.com

SilverSneakers (Anthem Members)

The SilverSneakers program is designed exclusively for retirees and offers physical activity, health education, and social events, including access to fitness equipment and group exercise classes at more than 15,000 SilverSneakers locations across the nation. Retirees can also access more than 8,000 virtual fitness events per month through SilverSneakers On-Demand and SilverSneakers LIVE on computers, Roku, or mobile devices.

To get started, simply show your SilverSneakers ID number at the front desk of any SilverSneakers participating location. Visit silversneakers.com/starthere to:

- Get your SilverSneakers ID number
- Find participating locations
- See class descriptions

If you have questions about SilverSneakers, call 1-888-423-4632.

Silver&Fit (Kaiser Permanente Members)

The Silver&Fit program helps you achieve a better life balance through flexibility, personalized support, and the following features tailored to meet your unique needs:

National Network of 14,000+ fitness centers

- No-cost membership at one of 14,000+ participating fitness centers and YMCAs
- Group fitness classes tailored to older adults
- Dance, yoga studios, and/or swimming pools

ASHConnect Mobile App

- Search feature with photos and location details to help you find fitness centers and YMCAs that best fit your needs. Activity tracking on over 250 wearable fitness devices, including Apple Watch, apps, and exercise equipment[1]
- Virtual streaming group exercise videos so you can work out on your schedule

Home Fitness Kits

- Receive up to 2 kits per benefit year to work out at home
- 35 unique options available, including a Fitbit® Connected! Kit[1]

If you have questions about the Silver&Fit program, call 1-877-750-2746.

[Stay tuned for communication from Kaiser Permanente about fitness program changes effective 1/1/2025.]

[1]Purchase of a wearable fitness device or application may be required and is not reimbursed by theSilver&Fit® program.

PRESCRIPTION DRUGS

WHAT IS A FORMULARY?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. For your carrier's formulary drug list, please visit anthem.com/ca/pharmacyinformation or kp.org/formulary.

Mail Order

Anthem Blue Cross and CarelonRx offer a Home Delivery option if you take prescribed medications on a regular basis. You can get up to a 90-day supply of your monthly prescription which saves you fewer refills and lower out of pocket costs. Your medications come right to your doorstep with standard shipping at no cost to you. Download the Sydney App or you can set up an account at anthem.com/register and access most of the same features from your computer.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

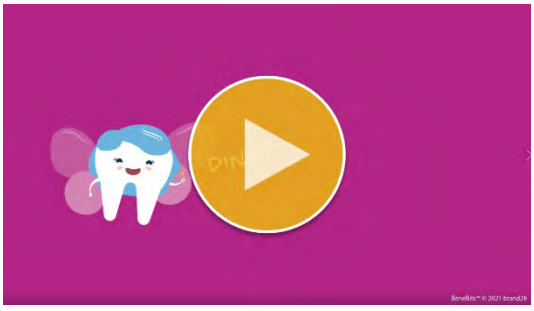
Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

DENTAL

OUR PLANS

Delta Dental PPO

Click to play video



We offer a dental plan through Delta Dental.

Why Sign Up For Dental Coverage?

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

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

Dental insurance covers four types of treatments:

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

Dental – Full Time Employees

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

	Delta Dental PPO	
	In-Network	**Out-of-Network**
Calendar Year Deductible	$0 per individual $0 per family	$0 per individual $0 per family
Calendar Year Plan Maximum	$2,100 per individual	$2,000 per individual
Diagnostic & Preventive Exams, two cleanings, and x-rays	Plan pays 70%-100%	Plan pays 70%-100%
Basic Services Fillings Root Canals Periodontics	Plan pays 70%-100%	Plan pays 70%-100%
Major Services Crowns Inlays Onlays Cast Restorations	Plan pays 70%-100%	Plan pays 70%-100%
Orthodontia Adults Children	Plan pays 50%	Plan pays 50%
Ortho Lifetime Max	$2,000	$2,000

What you need to know about this plan

Features:	See any provider, but you'll pay more out of network
Am I restricted to in-network providers?	No
Do I have to select a primary dentist?	No
Can I use my FSA?	If you participate in a healthcare FSA you can use your account to pay for dental expenses.
Where can I get more details?	Visit deltadental.com or download the Delta Dental app.

DELTA DENTAL RESOURCES

Delta Dental Mobile App

Anyone can use Delta Dental Mobile without logging in to access our Find a Dentist and Toothbrush Timer tools, conveniently located on the home screen. You also have the option to save your ID card to the home screen for easy access without logging in. Log into the app to view your personal benefits.

Amplifon & Qualsight Discounts

With the Amplifon discount, Delta Dental members get an average savings of 62% off the latest retail hearing aid price. Members may even be able to use their plan benefits in coordination with Amplifon discounts. There is also a QualSight discount for Delta Dental members. Members receive 40-50% off the national average price of traditional LASIK eye surgery when you use an experienced QualSight LASIK surgeon.

For more information on Amplifon's hearing aid discounts, visit amplifonusa.com/lp/deltadentalins or call 888-779-1429.

For more information on Qualsight's LASIK discounts, visit qualsight.com/-delta-dental or call 855-248-2020.

VISION

OUR PLANS

VSP Signature

Click to play video

We offer a vision plan through VSP.

Why Sign Up For Vision Coverage?

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

You'll even find discounts on hearing aids and other related services. Visit the plan's website to check out these extra savings.

Vision

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Signature
	In-Network
Exams Wellvision Exam Benefit Frequency	 $10 copay Once every 12 months
Diabetic Eyecare Plus Program[1]	$20 copay
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 No charge No charge No charge Once every 12 months
Frames Benefit Frequency	 $120 allowance $140 allowance on featured frame brands (Anne Klein, Bebe, Calvin Klein, Flexon, Lacoste, Nine West, and more) + 20% off the remaining balance Once every 12 months
Contacts (In lieu of glasses) Conventional Medically Necessary Frequency	 $120 allowance Covered in full Once every 12 months

[1]Diabetes annually accounts for $245 billion in total medical costs and lost work and wages that is why VSP created a program that provides coverage for additional eyecare services specifically for members who need them the most. Learn more about this program on the next page plus other VSP member exclusive discounts.

What you need to know about this plan

Features:	See any provider, but you'll pay more out of network
What other services are covered?	The plan can also help you save money on sunglasses, computer glasses, and even hearing aids.
Eyeglasses are expensive. Will I still be able to afford them, even with insurance?	Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.
Where can I get more details?	Visit vsp.com to learn more

VSP SAVINGS AND RESOURCES

ACCESS TO OVER $3,000 IN EXCLUSIVE MEMBER SAVINGS

Visit vsp.com/offers to learn more about these resources and other VSP exclusive member extras.

Extra Savings on Glasses and Sunglasses

Get an extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. You can also save 30% on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.

Retinal Screening

You won't pay more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.

LASIK - Laser Vision Correction

You can save up to 15% off the regular price of LASIK or 5% off the promotional price. Discounts are only available from contracted facilities. After surgery, you can use your frame allowance (if eligible) for sunglasses from any VSP doctor.

TruHearing Hearing Aid Discount

VSP® Vision Care members can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too. TruHearing also provides members with:

- 3 provider visits for fitting, adjustments, and cleanings
- A 45-day trial
- 3-year manufacturer's warranty for repairs and one-time loss and damage
- 48 free batteries per hearing aid

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call (877)396-7194.

VSP Diabetic Eyecare Plus Program

This program provides coverage of additional eyecare services specifically for members with diabetic eye disease, glaucoma or age-related macular degeneration (AMD). Eligible members can receive both routine and follow-up medical eyecare from their VSP doctor—the doctor who already knows their eyes best.

The program also provides supplemental coverage for non-surgical medical eye conditions such as diabetic retinopathy, abnormal blood vessel growth on the eye (rubeosis), and diabetic macular edema. Members can self-refer, visit their VSP Provider as often as needed, and pay only a copay for services.

FIND A PROVIDER

CARRIER APPS
You can also use the carrier apps to search for providers. Download from the App Store or Google Play.

Anthem Blue Cross

1. Call Member Services number at the back of your ID card, or visit anthem.com/ca/find-care.
2. Log into your Anthem account
3. Click “Care”, enter type of doctor (specialty), service or condition on the search box
4. Click on the “Sort By,” “Distance,” and “Refine your search” buttons to customize the results.
5. You can also do a customized search without logging in to your anthem.com account by typing your Member ID#.
6. You can also search as guest by selecting “Type of Care – Medical” > “State” > “Type of Plan: Medical (Employer Sponsored) or Medicare” > “Plan/Network: Medical (Employer Sponsored): EPO

Delta Dental

1. Call the Member Services number on the back of your ID card or visit deltadentalins.com.
2. Look for the Find a Dentist tool on the right. Enter a location (address, ZIP code, or city and state).
3. Under “Network,” select “Delta Dental PPO” from the drop-down menu. For a more targeted search, you can enter the name of your dentist or dental office below.
4. Click “Search”

VSP

1. Call Member Services at 800-877-7195 or visit vsp.com.
2. Click on “Find a Doctor” tab. Enter a location (address, ZIP code, or city and state)
3. Click “Search”

WELLBEING & BALANCE

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

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

A Happier, Healthier You

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

We offer programs to help you:

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

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone
800-834-3773

Website
claremonteap.com

Employer Code:
CONTRACOSTA

Help for you and your household members

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

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

No cost EAP resources

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

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 10 face-to-face or telephonic consultations per issue, per benefit year.
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

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

PARENTING & CHILDCARE

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

FINANCIAL COACHING

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

LEGAL CONSULTATION

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

ELDERCARE RESOURCES

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

ONLINE RESOURCES

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

IMPORTANT PLAN INFORMATION

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

- Your benefit contributions
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Provider	Phone Number	Website	Policy No.
Anthem Blue Cross Member Services	(855) 333-5730	anthem.com/ca	277996
Anthem Prescription	(800) 700-2541	anthem.com/ca	277996
Anthem Nurseline	(800) 337-4770	anthem.com/ca	277996
Anthem Blue Cross – Telemedicine (LiveHealth)	(844) 784-8409-Medical (844) 784-8409-Psychology (888) 548-3432-Psychiatry	livehealthonline.com	277996
Kaiser Permanente Member Services	(800) 464-4000	kp.org	162
Delta Dental	(866) 499-3001	deltadentalins.com	00621
VSP Vision Service Plan	(800) 877-7195	vsp.com	104331
Claremont Employee Assistance Program	(800) 834-3773	claremonteap.com	CONTRA COSTA
Navia Benefit Solutions (FSA)	(866) 897-1996	naviabenefits.com	YDC
4CD Employee Benefits Team			
Clarissa Cadena	(925) 229-6863	ccadena@4cd.edu	N/A
Renita Mack	(925) 229-6855	rmack@4cd.edu	N/A

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

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

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

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

View a sample notice and consent form (PDF).

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

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available here: 4cd.edu/hr/benefits. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Contra Costa Community College District Group Health Plan

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available here: 4cd.edu/hr/benefits.

- Anthem Medicare Preferred PPO with Senior Rx Plus
- Kaiser Permanente Senior Advantage
- Delta Dental PPO

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Contra Costa Community College District Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Medicare Part D Notice

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Contra Costa Community College District Group Health Plan coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under the Anthem and Kaiser medical plans are creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Contra Costa Community College District Group Health Plan changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

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

Date:	7/1/2024
Name of Entity/Sender:	Contra Costa Community College District
Contact-Position/Office:	Renita Mack
Address:	500 Court Street, Martinez, CA 94553
Phone Number:	925-229-6855

Frequently Asked Questions On Medicare Part D

If I am a retired District participant with Kaiser Senior Advantage or the Anthem Medicare Preferred PPO plan, do I need to do anything now?

If you stay with one of the District's sponsored Medicare plans, no action is required. You cannot be enrolled in more than one Part D plan at a time, so if you attempt to sign up with another Part D provider you risk being disenrolled from your medical and drug coverage.

If I am an active District participant, or a retired participant not with Kaiser Senior Advantage or the Anthem Medicare Preferred PPO plan, do I need to do anything now?

No, you can keep using the District's prescription drug program the same as you always have. Your copayments will not change, nor will any pharmacy network.

When you first become eligible for Medicare, you will have the option to independently enroll in a Medicare Part D prescription drug plan. However, by enrolling in a Part D plan you will permanently lose your current prescription drug coverage under the Contra Costa Community College District and you will not be reimbursed for your Part D premiums. As mentioned above, the standard Part D benefit is not as good as the District's own prescription drug program as described in your Health Plan Evidence of Coverage found at www.4cd.edu, select human resources and benefits.

You should compare your current prescription drug program, including which drugs are covered, with the benefits and costs of the Medicare Part D plans available in your area. To view the official summary of approved Medicare Part D plans in any of the United States, visit https://www.medicare.gov/find-a-plan/questions/home.aspx. Note that a Part D plan might not include your regular prescription drugs on its formulary. The District cannot provide you with a complete comparison of available Part D plans, but we urge you to carefully review any descriptions you may obtain.

So why do I need to keep my notice of creditable coverage?

In case you ever drop or lose your District coverage, or in the unlikely event that District coverage becomes non-creditable, having this notice will allow you to immediately enroll in a Part D plan without having to pay a late enrollment penalty. Specifically, if you try to enroll after your initial eligibility period, you will be charged a permanent Part D premium surcharge of 1% for every month since your initial Medicare eligibility for which you cannot show that you had creditable coverage (if such non-creditable period exceeds 62 days). Also note that you may have to wait for the next regular annual Part D enrollment period, which will be October 15th through December 7th for coverage in the following calendar year.

How can I get more information on Medicare Part D?

More detail will be in the handbook "Medicare & You" that will be mailed to individuals who are Medicare eligible by Medicare in October of each year. You may also be contacted directly by Medicare-approved Part D providers. At any time, you can visit http://www.medicare.gov/ or call 1-800- MEDICAR (1-800-633-4227). TTY users should call 1-877-486-2048.

Every state has a Health Insurance Assistance Program to help Medicare beneficiaries and their families with their health insurance choices and with problems that might arise. In California it is called the "Health Insurance Counseling and Advocacy Program" (HICAP) and can be reached (by non-cell phones only) at 1-800-434-0222.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration website at http://www.socialsecurity.gov/ or call them at 1-800-772-1213. TTY users should call 1-800-325-0778.

INITIAL IRMAA DETERMINATION

The Social Security Administration (SSA) makes initial determinations whether the income-related monthly adjustment amount (IRMAA) applies to Medicare beneficiaries with Part B, or Medicare prescription drug coverage (or both if enrolled in both at the time a determination is made) using IRS data. Beneficiaries receive a notice with information about SSA's determination and appeal rights when SSA makes an initial IRMAA determination for either Medicare Part B or Medicare prescription drug coverage.

If a beneficiary has Medicare Part B or Medicare prescription drug coverage only and enrolls in the other program later in the same premium year, the IRMAA determination will automatically be applied to the subsequent enrollment. A Title II Redesign (T2R) notice, which is not an IRMAA specific notice, is sent with the new IRMAA information and appeal rights. These notices will be stored on the Online Retrieval System.

IRMAA MEDICARE PART B AND PRESCRIPTION DRUG COVERAGE PREMIUMS SLIDING SCALE TABLE

The income-related monthly adjustment amount (IRMAA) sliding scale is a set of statutory percentage-based tables to adjust Medicare Part B and prescription drug coverage premiums. The higher the beneficiary's range of modified adjusted gross income (MAGI), the higher the IRMAA will be. There are three sets of tables. Each table is based on the beneficiary's tax filing status.

IRMAA TABLES, MEDICARE PART B PREMIUM YEAR 2024

1. Tax filing status

Single, head of household or qualifying widow(er) with dependent child	**Married, filing jointly**	**Then the Part B Premium is:**	**Prescription Drug Coverage Premium is :**
$103,000 or less	$206,000 or less	$174.70	Your plan premium
above $103,000 up to $129,000	above $206,000 up to $258,000	$244.60	$12.90 +your plan premium
above $129,000 up to $161,000	above $258,000 up to $322,000	$349.40	$33.30 +your plan premium
above $161,000 up to $193,000	above $322,000 up to $386,000	$454.20	$53.80 +your plan premium
above $193,000 and less than $500,000	above $386,000 and less than $750,000	$559.00	$74.20 +your plan premium
$500,000 or above	$750,000 or above	$594.00	$81.00 +your plan premium

* Plus any applicable surcharges, minus any Medicare Advantage Reduction. (See SM 03040.335 for Medicare Advantage Reduction)

2. Tax filing status: married, filing separately

If your Modified Adjusted Gross Income (MAGI) is:	**Then the Part B Premium is:**	**Prescription Drug Coverage Premium is:**
$103,000 or less	$174.70	You plan premium
Above $103,000 and less than $397,000	$559,000	$74.20 +your plan premium
$397,000 or above	$594,000	$81.00 +your plan premium

Source: Medicare.Gov

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered By Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name		4. Employer Identification Number (EIN)
CONTRA COSTA COMMUNITY COLLEGE DISTRICT		68-0342035
5. Employer address		6. Employer phone number
500 Court Street		(925) 229-1000
7. City	8. State	9. ZIP Code
Martinez	CA	94553
10. Who can we contact about employee health coverage at this job?		
Renita Mack		
11. Phone number (if different from above)		12. Email address
(925) 229-6855		rmack@4cd.edu

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  All employees. Eligible employees are:

  ☐

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☐ We do offer coverage. Eligible dependents are:

  ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? ~~(mm/dd/yyyy) (Continue)~~

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard?

☐ Yes (go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets minimum value standard offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't received any other discounts based on wellness programs.
   a. How much would the employee have to pay in premiums for this plan? $_____
   b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets minimum value standard. (Premium should reflect the discount for wellness programs. See question 15.)

   a. How much would the employee have to pay in premiums for this plan? $_____
   b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under 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 of the following qualifying events:

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

Bankruptcy under Title 11
Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Contra Costa Community College District and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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 within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, **Children's Health Insurance Program (CHIP),** or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about 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.

Plan contact information
The Contra Costa Community College District, Human Resources Department, 500 Court Street, Martinez CA by phone at 925-229-6935 or by email at DOHR@4cd.edu.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: all deductibles/coinsurance under the Anthem and Kaiser plans. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Contra Costa Community College District's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

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

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

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Contra Costa Community College District describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the plan administrator.

Notice of Choice of Providers

HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator.

Michelle's Law

The Anthem and Kaiser plans may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify Contra Costa Community College District as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

ACA Disclaimer

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

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp | Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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


Contra Costa
Community
College District
pathways to success