

2024-2025

CONTRA COSTA COMMUNITY COLLEGE DISTRICT ACTIVE EMPLOYEE BENEFITS

7/1/24 – 6/30/25



FRESH LOOK AT BENEFITS



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.

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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, permanent hired and adjunct employees are eligible for the benefits outlined in this overview.

ACTIVES: You will be eligible for plans for active employees if you are hired as a permanent employee.

ADJUNCT: You are eligible to enroll in plans assigned for part-time faculty (medical, dental, and vision plans only) if you have an average load of 0.40 for the Fall and Spring semesters of the previous academic year or a load of .40 or higher in the current semester (not including Summer).

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

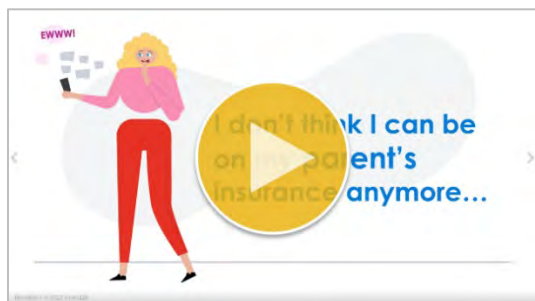
Coverage for new eligible employees begins on the First of the Month Following Date of Hire.

Open enrollment for current full-time employees is generally held from October 15 to November 15. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Open enrollment for adjuncts will take place in January and August.

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 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

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

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

You must submit your change within 30 days after the event.

What if I have other group medical coverage?

You have the option to waive these benefits if you have other group coverage (i.e., under your spouse). Upon submission of Cash in Lieu form & proof of other group coverage, you will receive a cash in lieu based on the negotiated union or employee group contract.



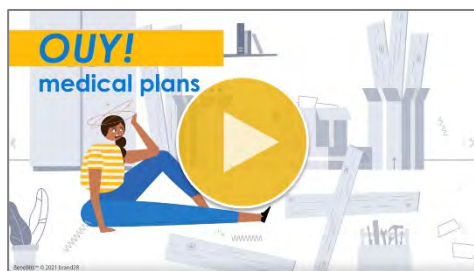
MEDICAL

OUR PLANS

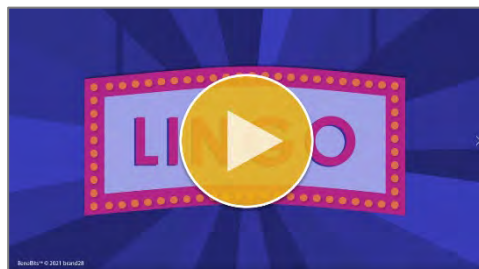
Anthem Blue Cross EPO Plan

Kaiser Permanente HMO Plan

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 Blue Cross EPO Plan	Kaiser Permanente HMO Plan
	In-Network Only	In-Network Only
Calendar Year Deductible		
Individual	\$0	\$0
Family	\$0	\$0
Calendar Year Out-of-Pocket Maximum^{1,4}		
Individual	\$1,500	\$1,500
Family	\$4,500	\$3,000
Embedded/Aggregate ³	Embedded	Embedded
Office Visit⁵		
Primary Care or Specialist	\$20 copay	\$20 copay
Online Visit	\$10 copay (through LiveHealth Online)	No charge (video consults)
Preventive Services	No charge	No charge
Chiropractic	No charge (24 visits/year)	\$15 copay (30 visits/year)
Acupuncture	No charge (30 visits/year)	Not covered
Lab and X-ray	No charge	No charge
Urgent Care	\$20 copay	\$20 copay
Emergency Room	\$50 copay (waived if admitted)	\$50 copay (waived if admitted)
Inpatient Hospitalization	No charge	\$100 copay
Outpatient Surgery	No charge	\$20 copay
PRESCRIPTION DRUGS		
Annual Deductible	None	None
Out-of-Pocket Maximum	Combined with medical	Combined with medical
Retail		
Tier 1 - Generic	\$10 copay	\$10 copay
Tier 2 - Preferred Brand	\$20 copay	\$20 copay
Tier 3 - Non-Preferred Brand	\$20 copay	Not covered
Tier 4 - Specialty	\$20 copay	\$20 copay (30 day supply only)
Supply Limit	30 days	100 days
Mail Order		
Tier 1 - Generic	\$10 copay	\$10 copay
Tier 2 - Preferred Brand	\$20 copay	\$20 copay
Tier 3 - Non-Preferred Brand	\$20 copay	Not covered
Tier 4 - Specialty	\$20 copay	Not covered
Supply Limit	90 days	100 days

¹Out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.

²An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

³Includes Mental Health and Chemical Dependency Services

⁴All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

⁵Includes mental health and chemical dependency services.

Please note: UF and Local 1 members should refer to their Collective Bargaining Agreements regarding medical copay reimbursements.

ANTHEM RESOURCES



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.

BlueCard PPO Program/Travel within the U.S.

If you are away from home and you need care right away, you're covered. As an Anthem Blue Cross member, you have access to care across the country through the BlueCard PPO Program. All services are covered. Go to anthem.com/ca, use the "Find Care" tool, and search for Blue Card PPO doctor or hospital. Or call the member services number on your ID card.

BlueCard PPO Program/Travel outside the U.S.

While travelling outside the US you are covered for Urgent Care and Emergency Care ONLY. The website for our Global Core program is www.bcbsglobalcore.com

Learn to Live

Learn to Live offers Emotional Well-being Resources to help you and your household live your happiest, healthiest lives. Access digital tools that can help you identify thoughts and behavior patterns that affect your emotional well-being and work through them. Learn effective ways to manage stress, depression, anxiety, substance use, and sleep issues.

Take a quick assessment to find the program that's right for you. To access Anthem's Emotional Well-being Resources, login to anthem.com/ca, go to My Health Dashboard and choose Programs, then Select Emotional Well-being Resources.

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



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.

Special Offers

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

KAISER RESOURCES

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

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

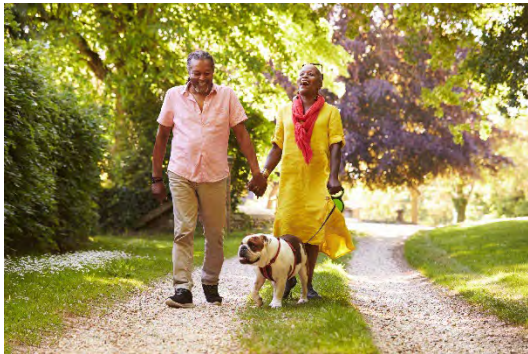


The number one app for meditation and sleep. Choose from hundreds of programs and activities including guided meditations, music, mindful movement, and sleep stories to help lower stress, reduce anxiety, and improve sleep quality. Available to members 13 years and over and no referral needed. Visit kp.org/selfcareapps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



FINDING 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](https://kp.org) or download the Kaiser Permanente app.

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](https://www.anthem.com/ca/pharmacyinformation) or [kp.org/formulary](https://www.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](https://www.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	<ul style="list-style-type: none"> Identifying symptoms Decide if immediate care is needed Home treatment options and advice 	24/7	\$0
Online visit 	Many non-emergency health conditions	<ul style="list-style-type: none"> Cold, flu, allergies Headache, migraine Skin conditions, rashes Minor injuries Mental health concerns 	24/7	\$
Office visit 	Routine medical care and overall health management	<ul style="list-style-type: none"> Preventive care Illnesses, injuries Managing existing conditions 	Office Hours	\$\$
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	<ul style="list-style-type: none"> Stitches Sprains Animal bites Ear-nose-throat infections 	Office Hours, or up to 24/7	\$\$\$
Emergency room 	Life-threatening conditions requiring immediate medical expertise	<ul style="list-style-type: none"> Suspected heart attack or stroke Major bone breaks Excessive bleeding Severe pain Difficulty breathing 	24/7	\$\$\$\$\$



DENTAL

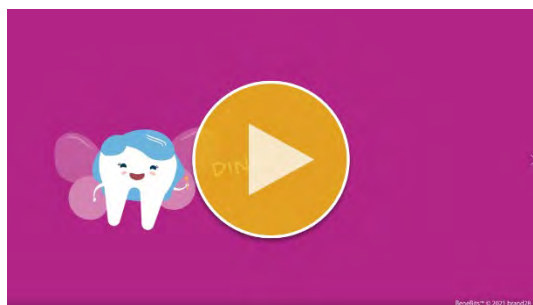
OUR PLANS

Delta Dental PPO – Full Time Employees

Delta Dental PPO – Part Time Faculty

Delta Care HMO – Part Time Faculty

Click to play video



We offer a dental plan for full time employees and 2 dental plans for part time faculty, all 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.

NOTE: For dental services amounting to at least \$300, it is suggested that you ask your provider's office to request a pre-determination estimate from Delta Dental. This ensures that your procedure is covered and helps you plan your payment in advance.

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 (up to age 26)	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.

Dental – Part Time Faculty

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

	Delta Dental PPO		Delta Care HMO Plan CA13A
	In-Network	Out-of-Network	In-Network Only
Calendar Year Deductible	\$50 per individual \$150 per family	\$75 per individual \$225 per family	\$0 per individual \$0 per family
Calendar Year Plan Maximum	\$1,000 per individual		None
Diagnostic & Preventive	Plan pays 100%	Plan pays 100%	\$0-\$10 copay
Basic Services Fillings Root Canals Periodontics	Plan pays 80%	Plan pays 80%	\$0-\$335 copay
Major Services Crowns Inlays Onlays Cast Restorations	Plan pays 50%	Plan pays 50%	\$145-\$355 copay
Orthodontia Adults Children	Not covered Plan pays 50% (up to age 26)	Not covered Plan pays 50% (up to age 26)	\$2,100 \$1,900 (up to age 19)
Ortho Lifetime Max	\$1,000		N/A

What you need to know about this plan



Features:

Am I restricted to in-network providers?

Do I have to select a primary dentist?

Can I use my FSA?

Where can I get more details?

With the PPO, you can see any provider, but you'll pay more out of network. With the HMO, you can only see in-network dentists, but will have lower, more predictable costs.

With the PPO: No
With the HMO: Yes

With the PPO: No
With the HMO: Yes

If you participate in a healthcare FSA, you can use your account to pay for dental expenses.

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

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.

Click to play video



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	No charge Once every 12 months
Diabetic Eyecare Plus Program¹	\$20 copay
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	\$10 copay \$10 copay \$10 copay Once every 12 months
Frames Benefit Frequency	\$170 allowance \$190 allowance on featured frame brands (Anne Klein, Bebe, Calvin Klein, Flexon, Lacoste, Nine West, and more) + 20% off remaining balance Once every 12 months
Contacts (In lieu of glasses) Conventional Medically Necessary Frequency	\$170 allowance Covered in full Once every 12 months

¹Diabetes 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](https://www.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](https://www.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](https://www.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](https://www.vsp.com).
2. Click on “Find a Doctor” tab. Enter a location (address, ZIP code, or city and state)
3. Click “Search”



LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

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

Is your family protected?

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

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

LIFE INSURANCE



Basic Life Insurance

Sunlife Basic Life

Full-Time Employees \$50,000

EVIDENCE OF INSURABILITY (EOI)

The Evidence of Insurability form must be completed if you elect supplemental, extended, or dependent life insurance after more than 31 days of employment. It also must be completed if you elect additional insurance above the guaranteed issue (\$150,000). This can be completed online through Sun Life.

If you have loved ones who depend on your income for support, having life insurance can help protect your family's financial security. Life Insurance pays your beneficiary a lump sum if you die.

Only full-time employees are eligible for this benefit. Coverage is provided by Sunlife Financial. Your District-paid and optional life policies come with the following options:

- **Living Benefits Option:** If you are diagnosed as terminally ill with a 12 month or less life expectancy, you may be eligible to receive payment of a portion of your life insurance. The remaining amount of your life insurance coverage will be paid out to your beneficiary when you die.
- **Life Conversion and Portability:** You can continue your life insurance coverage even after your employment with the District ends.
 - **Conversion:** Option to convert your term policy to a whole life policy that accumulates cash value and will be computed at individual insurance rate. Premiums for the converted policy will be substantially higher compared to the District-sponsored term plan.
 - **Portability:** Allows you to continue your life insurance coverage even if you are no longer employed with the District.

Additional Life Insurance

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

Sunlife Voluntary Life

Employee Amount of Coverage	Cost Per Month
\$50,000	\$16.90
\$100,000	\$33.80
Over \$100,000	Varies
Maximum Coverage	Up to 5x the salary or \$400,000, whichever is greater
Dependents (Spouse and Child Under 26)	
\$5,000	\$1.32

Note: Amount of dependent life insurance cannot exceed 50% of employee's coverage

LONG-TERM DISABILITY INSURANCE (LTD)



3 THINGS TO KNOW ABOUT LTD INSURANCE

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

LTD benefits cushion the financial impact of a disability

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

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

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

Sunlife LTD Plan

Monthly benefit amount	66.67% of total monthly earnings
Benefits begin	After 60 days of disability
Minimum monthly benefit	\$100 or 10% of gross monthly benefit, whichever is greater
Maximum monthly benefit	\$9,000
Maximum payment period	Up to age 65

SUN LIFE ADDITIONAL SERVICES

If you have District-paid life insurance coverage through Sunlife Financial, you will have access to the following services available at no extra cost:

Emergency Travel Assistance

If you have a medical emergency while you are more than 100 miles away from home, you don't have to face it alone. With one simple phone call, you can be connected to Assist America's staff of medically trained, multilingual professionals who can advise you in a medical emergency, 24x7. No matter where you are in the world, they will help you access or receive:

- Pre-qualified, English-speaking professionals working in hospitals, pharmacies, and dental offices
- Medical consultation, evaluation, and referral
- Hospital admission
- Critical care monitoring
- Emergency medical evacuation
- Transportation to return home or to a rehabilitation facility
- Lost prescription assistance
- Legal and interpreter services, and more

Here are a few things to keep in mind:

- Always carry your Assist America member ID card whenever you travel
- Assist America cannot reimburse participants for services that it did not provide

Identity Theft Protection

Identity theft is a serious crime and if you ever become a victim of identity theft, you don't have to face it alone. You have the support of a comprehensive Identity Theft Protection program through Assist America's SecurAssist Identity Protection program. It provides:

- 24x7 telephone support and step-by-step guidance by anti-fraud experts,
- A case worker assigned to you to help you notify the credit bureaus and file paperwork to correct your credit reports,
- Help canceling stolen cards and reissuing new cards, and
- Help notifying financial institutions and government agencies.



VOLUNTARY LONG-TERM CARE INSURANCE (LTC) CA Only



To file a claim online or to view submission instructions, visit www.TrustmarkVB/Claims

For any questions relating to claims, contact our claims team directly at (877) 201-9373 or ClaimContactVB@trustmarkbenefits.com

LTC benefits cushion the financial impact of a disability.

Turstmark Long-term Care Insurance includes the following benefits:

- **Professional Caregiving Benefit:** Death benefit accelerates 4% per month for professional care received for up to the face amount.
- **Family Caregiving Benefit:** Death benefit accelerates 2% per month, for **family care** received, for up to the face amount.
- **Extension of Caregiving:** Professional or family caregiving benefit amount is restored back to the face amount after the initial caregiving benefit amount is depleted. Not available for issue age 71-75.
- **Death Benefit Restoration:** Restores 100% of the death benefit accelerated under the Caregiving Benefit. Not available for issue age 71-75.
- **How Death Benefit Reduction works:** The death benefit reduces to 33% at age 70 or the 10th certificate anniversary, whichever is later.
- **Spouse Coverage**

Your Benefits

Stand-Alone Spouse Coverage

Employees may apply for Trustmark Life + Care for their spouse or domestic partner as well as for themselves. The spouses's plan will include the same features as theirs (spouse coverage is capped at a portion of the employee amount).

Interim Coverage – Your Life + Care coverage **begins as soon as you apply**, as long as you meet eligibility requirements.

Terminal Illness Benefit – **Advance up to 50%** of your death benefit if you're diagnosed with having less than 24 months to live.

Options to Convert – After you have had coverage for at least 10 years, you may elect to **pay no additional premiums** and **convert your plan** into either Extended Term or Reduced Paid-Up life insurance (death benefit and long-term care benefits). Details will depend on your plan, age, benefit amount and how long you have had coverage.

Portability – Keep your coverage at the same rate and benefits if you change jobs or retire.



FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

Healthcare Flexible Spending FSA

Dependent Care FSA

Transportation & Parking Benefits

Deferred Compensation

Is it time for a “financial wellness” checkup?

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

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

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

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video



ARE YOU ELIGIBLE?

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

- naviabenefits.com – access code YDC
- [Eligible Expenses](#) – now include more over-the-counter items!
- [Ineligible Expenses](#)

DO YOU PAY FOR DEPENDENT CARE?

Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

Set aside healthcare dollars for the coming year. A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through Navia.

How the Healthcare FSA works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to \$3200, the 2024 annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 1/1/2024 and 12/31/2024 and claims must be submitted for reimbursement no later than 3/31/2025. If you don't spend all the money in your account, you can rollover up to \$500 to use the following year. Any additional remaining balance will be forfeited.
- Elections cannot be changed during the plan year unless you experience a qualifying event.
- You must re-enroll in this program each year.

FSA TAX SAVINGS EXAMPLE

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

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

\$120,000 Annual Pay, with \$2,750 FSA Contribution

\$660	\$210	\$870
24% Federal income tax	7.65% FICA tax	Annual FSA tax savings

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

PAYING FOR DEPENDENT CARE? MAKE IT TAX-FREE!



EVERY OPPORTUNITY TO SAVE

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

Dependent Care FSA—up to \$5,000 per year tax-free

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

Here's how the Dependent Care FSA works

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

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



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

SAVE ON COMMUTE EXPENSES



Transportation Expense Account and Parking Expense Account

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by Navia.

A Transportation Expense Account lets you set aside money—before it's taxed—through payroll deductions. You may enroll and/or stop participating in this program at any time. Monies in this account can be used in future months or plan years. If you leave the District, any unused account balance will be lost. These amounts are evaluated annually by the IRS and are subject to change.

Parking Expense Account	Up to \$280 per month
Transportation Expense Account	Up to \$280 per month

DEFERRED COMPENSATION



Setting up your 403(b)/457 Tax Sheltered Annuity only involves a few easy steps

New accounts and rollover instructions:

1. Select a vendor from the District's vendor list of Tax Sheltered Annuity 403(b) companies found at the District website under Human Resources, Benefits, and Deferred Compensation 4cd.edu/hr/payroll/docs/403b-457-Tax-Sheltered-Annuities.pdf
2. Contact the 403(b)/457 company to receive enrollment forms.
3. Complete the paperwork from the 403(b)/457 company to establish an account with the 403(b) company.
4. When rolling an account over or establishing a new account, provide the 403(b) company with the District code found on the vendor list in step 1.
5. Once confirmation has been received that the account is active, please complete the Payroll Deduction Authorization Form found on the InSite Portal under the HR-Payroll Tile.

Direct Rollover and Loan Authorization

Please contact your existing vendor directly for information and to begin the process. They will provide you directions and paperwork that you will need to complete. Once your paperwork is ready to be signed by the Plan Administrator, please send it to the District Office via interoffice mail, USPS, or for quicker response, you may email the forms to DOPQ@email.4cd.edu.

Please note: Information and Enrollment Forms pertaining to CalPERS Supplemental Income 403(b)/457 Plan or the CalSTRS Pension 2 Personal Wealth Plan 403(b)/457 are found on the District website under Deferred Compensation.



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)



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

CONTACT THE EAP

Phone

800-834-3773

Website

claremonteap.com

Employer Code:

CONTRACOSTA

Download the Uprise Health app to access the EAP on the go!



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.

FULL-TIME EMPLOYEE BENEFIT RATES

Contra Costa Community College District Active Employee Benefit Rates

Fiscal Year 2024 - 2025

Benefit Type	Coverage Type	Total Monthly Premium	*Local1 and UF 6%	District Rate	*Unrep. 12%	District Rate
Kaiser (HMO)	Single	\$ 1,080.63	\$ 64.84	\$1,015.79	\$ 129.68	\$ 950.95
	2-Party	\$ 2,161.25	\$ 129.68	\$2,031.58	\$ 259.35	\$1,901.90
	Family	\$ 3,058.17	\$ 183.49	\$2,874.68	\$ 366.98	\$2,691.19
Blue Cross (EPO)	Single	\$ 1,601.31	\$ 96.08	\$1,505.23	\$ 192.16	\$1,409.15
	2-Party	\$ 3,362.71	\$ 201.76	\$3,160.95	\$ 403.53	\$2,959.18
	Family	\$ 4,803.86	\$ 288.23	\$4,515.63	\$ 576.46	\$4,227.40
Delta Dental	Single	\$ 66.05	\$ 3.96	\$ 62.09	\$ 7.93	\$ 58.12
	2-Party	\$ 112.30	\$ 6.74	\$ 105.56	\$ 13.48	\$ 98.82
	Family	\$ 171.76	\$ 10.31	\$ 161.45	\$ 20.61	\$ 151.15
Vision Service Plan	Single	\$ 13.65	\$ -	\$ 13.65	\$ -	\$ 13.65
	2-Party	\$ 27.29	\$ -	\$ 27.29	\$ -	\$ 27.29
	Family	\$ 46.68	\$ -	\$ 46.68	\$ -	\$ 46.68
Employee Assistance Program (EAP)	Single/Family	\$ 3.25	\$ -	\$ 3.25	\$ -	\$ 3.25
Cash Stipend	<i>In Lieu of Medical Plan</i>	\$ 600.00	\$ -	\$ 600.00	\$ -	\$ 600.00
Sun Life	Basic (\$50,000)	\$ 7.10	\$ -	\$ 7.10	\$ -	\$ 7.10
	Supplemental (\$50,000)	\$ 16.90	\$ 16.90	\$ -	\$ 16.90	\$ -
	Extended (\$50,000)	\$ 16.90	\$ 16.90	\$ -	\$ 16.90	\$ -
*6% contribution rate does not apply to life insurance	Dependent Life (\$5,000) must have \$50,000 of supplemental insurance	\$ 1.32	\$ 1.32	\$ -	\$ 1.32	\$ -

PART-TIME FACULTY BENEFIT RATES

“RATES ARE PRORATED

Fall - monthly premium is multiplied by 12 (number of coverage months) then divided by 10 (number of paycheck deductions)

Spring – monthly premium is multiplied by 7 (number of coverage months) then divided by 5 (number of remaining paycheck deductions) “

Benefit Plan	Coverage Type	Total Monthly Premium	30-39% - Average Load for Previous Academic Year (dental/vision only) (Fall 2023 & Spring 2024)		40-59% - Average Load for Previous Academic Year (dental/vision only) (Fall 2023 & Spring 2024)		60% or Greater Average Load for Previous Academic Year (dental/vision only) (Fall 2023 & Spring 2024)	
			Instructor Pays 60%	District Pays 40%	Instructor Pays 50%	District Pays 50%	Instructor Pays 25%	District Pays 75%
Delta (PPO)	Employee	\$66.25	\$39.75	\$26.50	\$33.13	\$33.13	\$16.56	\$49.69
	Employee + 1	\$109.91	\$65.95	\$43.96	\$54.96	\$54.96	\$27.48	\$82.43
	Employee + 2 or more	\$175.32	\$105.19	\$70.13	\$87.66	\$87.66	\$43.83	\$131.49
Delta Care (DHMO)	Employee	\$19.24	\$11.54	\$7.70	\$9.62	\$9.62	\$4.81	\$14.43
	Employee + 1	\$31.74	\$19.04	\$12.70	\$15.87	\$15.87	\$7.94	\$23.81
	Employee + 2 or more	\$46.92	\$28.15	\$18.77	\$23.46	\$23.46	\$11.73	\$35.19
Vision Services Plan <i>Instructor Pays Full Premium</i>	Employee	\$18.97	\$18.97	\$0.00	\$18.97	\$0.00	\$18.97	\$0.00
	Employee + 1	\$37.94	\$37.94	\$0.00	\$37.94	\$0.00	\$37.94	\$0.00
	Employee + 2 or more	\$61.10	\$61.10	\$0.00	\$61.10	\$0.00	\$61.10	\$0.00
MEDICAL								
NEW ENROLLEES MUST AVERAGE .40 FOR FALL 2023 & SPRING 2024 (SUMMER LOAD COUNTS IN SPRING). EFFECTIVE FALL 2024 ADJUNCTS ALREADY ENROLLED IN MEDICAL MUST AVERAGE .40 FOR FALL 2023 & SPRING 2024 (SUMMER LOAD COUNTS IN SPRING) OR MAINTAIN A LOAD OF .40 OR HIGHER IN THE CURRENT SEMESTER TO CONTINUE BEING ELIGIBLE FOR MEDICAL.								
Kaiser (HMO) Adjuncts pay 6%	Employee	\$1,080.63	\$64.84	\$1,015.79	\$64.84	\$1,015.79	\$64.84	\$1,015.79
	Employee + 1	\$2,161.25	\$129.68	\$2,031.58	\$129.68	\$2,031.58	\$129.68	\$2,031.58
	Employee + 2 or more	\$3,058.17	\$183.49	\$2,874.68	\$183.49	\$2,874.68	\$183.49	\$2,874.68
Anthem (EPO) Adjuncts pay 3%	Employee	\$1,601.31	\$48.04	\$1,553.27	\$48.04	\$1,553.27	\$48.04	\$1,553.27
	Employee + 1	\$3,362.71	\$100.88	\$3,261.83	\$100.88	\$3,261.83	\$100.88	\$3,261.83
	Employee + 2 or more	\$4,803.86	\$144.12	\$4,659.74	\$144.12	\$4,659.74	\$144.12	\$4,659.74

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 Full-time Faculty			
PPO	(866) 499-3001	deltadentalins.com	00621
Delta Dental Part-Time Faculty			
PPO	(800) 765-6003	deltadentalins.com	00965 (PPO)
DHMO	(800) 422-4234	deltadentalins.com	71691 (DHMO)
VSP Vision Service Plan	(800) 877-7195	vsp.com	104331
Sun Life Financial	(800) 247-6875	www.sunlife.com	80816
Trustmark	(877) 201-9373 Claims (800) 918-8877 Customer Service	www.TrustmarkVB/Claims	300000 2813
Claremont Employee Assistance Program	(800) 834-3773	claremonteap.com	CONTR A COSTA
Navia Benefit Solutions (FSA)	(866) 897-1996	naviabenefits.com	YDC
Deferred Compensation	(925) 229-6860	kmyers@4cd.edu	N/A
4CD Employee Benefits Team			
Clarissa Cadena – Employee Benefits Specialist	(925) 229-6863	ccadena@4cd.edu	N/A
Renita Mack – Benefits Analyst	(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 Blue Cross EPO Plan
- Kaiser Permanente HMO Plan
- Delta Dental PPO Plan
- Delta Dental DHMO Plan

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](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

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

Date:	July 1, 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.

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

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 January 31, 2024. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: 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: KIHIPPPROGRAM@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.medicicaid.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: HSHSHIPPPProgram@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.pa.gov/en/services/dhs/apply-for-medicaid-benefits.html 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 Rlite 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

