Contra Costa Community College District

pathways to success

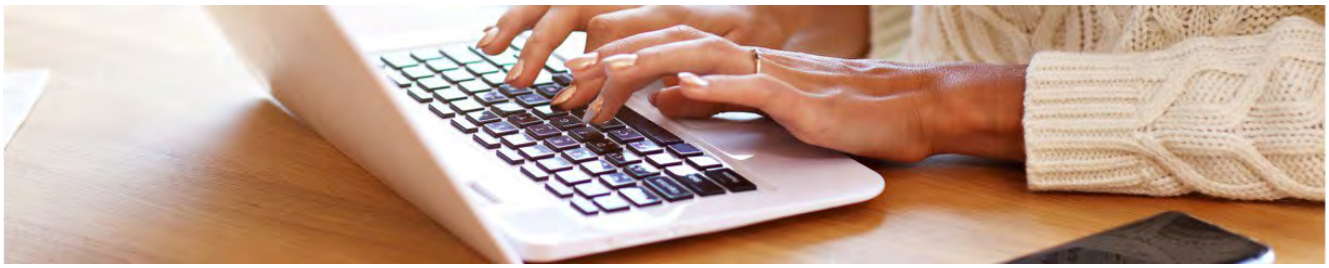
Contra Costa Community College District
Active Employee Benefits Overview
July 1, 2023 to June 30, 2024

Open Enrollment
October 15th to November 15th

TABLE OF 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 Annual Notices for more details.

Let's Talk Benefits



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 www.4cd.edu/hr/benefits.

The benefits in this summary are effective:

July 1, 2023, to June 30, 2024

NEW **Benefit plan changes for 2023/2024**

Current	New for 2023/2024
VSP - Frame retail allowance $155 VSP – Featured brands allowance $175 VSP – Contact lens allowance $105	VSP – Frame retail allowance $170 VSP – Featured brands allowance $190 VSP – Contact lens allowance $170
MHN Employee Assistance Program (EAP)	New carrier: Claremont Employee Assistance Program (EAP)

Need help to Find a Dentist

- Call the Member Services number on the back of your ID card or go to deltadentalins.com.
- Look for the Find a Dentist tool on the right. Enter a location (address, ZIP code, or city and state).
- 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.
- Click Search.

Who Can You Cover?

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
0.30 for the Fall and Spring semesters of the previous academic year and working 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?

Family 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 CAN I 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.

Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election.
Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 31 days to make your change.

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.

Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

WHEN YOU NEED CARE NOW

What do you do when you need care right away but it's not an emergency?

Kaiser Permanente Plan Participants

- Call Kaiser's 24-hour appointment and advice line at (866) 454-8855
- Find an urgent care center by visiting kp.org

Anthem Medical Plan Participants

- Call Anthem's 24/7 NurseLine at 800-977-0027
- Find an urgent care center by visiting anthem.com/ca
- Use Anthem LiveHealth Online

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life-threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require the use of a hospital or ER. Urgent care conditions include but are not limited to earache, sore throat, rashes, sprains, flu, and fever up to 104°.

GET A VIDEO HOUSE CALL

Anthem and Kaiser members can video chat with a doctor from the comfort of their own homes without an appointment.

Kaiser Members: Check with your Primary Care Physician if they can schedule your next appointment via a video visit. When scheduling an appointment in person or through the Appointment and Advice Line, ask if a video visit is right for your symptoms. For more information, visit www.kp.org/mydoctor/videovisit.

Anthem Members: LiveHealth Online provides 24/7 access to U.S. board-certified physicians who can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy.

For more information on your telehealth benefits, please refer to page 8.

Choosing an In-Network PPO Provider

Choosing a healthcare provider that is participates in your plan's network makes your service experience stress-free. This will also save you money as in-network providers have a contract to accept an agreed fee and that means predictable out-of-pocket costs for you.

ANTHEM BLUE CROSS

- Call Member Services number at the back of your ID card, or
- Go to anthem.com/ca/find-care

Log in to your Anthem.com account (recommended)

- Log-in to your Anthem account.
- Click "Care", enter type of doctor (specialty), service or condition on the search box
- Click on the "Sort By," "Distance," and "Refine your search" buttons to customize the results.
- You can also do a customized search without logging in to your anthem.com account by typing your Member ID#.

If searching as a Guest, select:

- Type of Care - Medical
- State
- Type of Plan: Medical (Employer Sponsored) or Medicare
- Plan/Network: Medical (Employer Sponsored): EPO

DELTA DENTAL

- Call Member Services number on the back of your ID card, or
- Go to deltadentalins.com
- Look for the Find a Dentist tool on the right. Enter a location (address, ZIP code, or city and state).
- 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.
- Click Search.

VSP

- Call Member Services at (800) 877-7195, or
- Go to vsp.com
- Click on "Find a Doctor" tab. Enter a location (address, ZIP code, or city and state).
- Click Search.

HELPFUL TIP:

Before setting an appointment with your chosen provider, make sure to confirm that they have an existing contract with your plan's network.

Medical

Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

Contra Costa Community College District gives you a choice between medical plans through Anthem Blue Cross and Kaiser Permanente.

	Anthem Blue Cross EPO Plan	Kaiser Permanente HMO Plan
	In-Network	**In-Network**
Annual Deductible	$0 per individual $0 family limit	$0 per individual $0 family limit
Annual Out-of-Pocket Max	$1,500 per individual $4,500 family limit	$1,500 per individual $3,000 family limit
Lifetime Max	Unlimited	Unlimited
Office Visit[1]		
Primary Provider or Specialist	$20 copay per visit	$20 copay per visit
Retail Health Clinic or Online Visit	$10 copay per visit	No charge (Video Consults)
Preventive Services	No charge	No charge
Acupuncture	No charge (30 visits/year)	Not covered
Chiropractic Care	No charge (24 visits/year)	$15 copay per visit (up to 30 visits per year)
Lab and X-ray	No charge	No charge
Advanced Imaging (MRI/PET/CAT Scans)	No charge (Subject to utilization review).	No charge
Inpatient Hospitalization[1]	No charge	$100 per admission
Outpatient Surgery	No charge	$20 copay per procedure
Urgent Care	$20 copay per visit	$20 copay per visit
Emergency Room	$50 copay per visit (copay waived if admitted)	$50 copay per visit (copay waived if admitted)

[1]Includes Mental Health and Chemical Dependency Services

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

Medical

ALTERNATIVE ACCESS TO CARE

Use LiveHealth Online to have a video visit with a doctor on your smartphone, tablet, or computer with a webcam. Online visits using LiveHealth Online are a covered benefit under your Anthem health plan.

Sign up quick, easy and for free today at livehealthonline.com or download the app (IOS and Android) so you can get access to board-certified doctors 24/7 for a $10 copay. Doctors using LiveHealth Online can provide medical care for common conditions, like the flu, colds, pink eye and more. And they'll even send prescriptions to the pharmacy of your choice if needed.

Sydney Health

To begin your journey, Sydney Health, our mobile app, and anthem.com/ca give you a new way to focus on your health in one convenient place. Download Sydney Health and register on the app to take full advantage of your Anthem plan, including:

- Medical benefits and spending accounts
- Integrated pharmacy benefits
- Integrated clinical programs along with well-being tools and resources
- Smart provider search and transparency tools

Nurseline 24/7

Receive answers to your health questions wherever you are, day or night. The line is staffed by registered nurses to talk to about your general health issues. They can help you determine if you can treat your issue at home if you need to make an appointment to see your doctor, or if you should head to urgent care or the emergency room. (800) 337-4770

BlueCard PPO Program/Travel

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. 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. Urgent & Emergency Care services are only available while traveling.

Get the care you need the way you want it. No matter which option you choose, your providers can see your health history, update your medical record, and give you personalized care that fits your life.

Choose where, when, and how you get care.

Call Kaiser Permanente anytime at 1-866-454- 8855 (TTY 711) to make an appointment or to speak to an advice nurse.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider.

Email

Message your doctor's office with non-urgent questions anytime. Sign on to kp.org or use our mobile app.

Phone appointment

Save yourself a trip to the doctor's office for minor conditions or follow-up care.

Video visit

Meet face-to-face online with a doctor on your computer, smartphone, or tablet for minor conditions or follow-up care.

My Doctor Online app

Care for yourself and your family - anytime, anywhere

Our app 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.

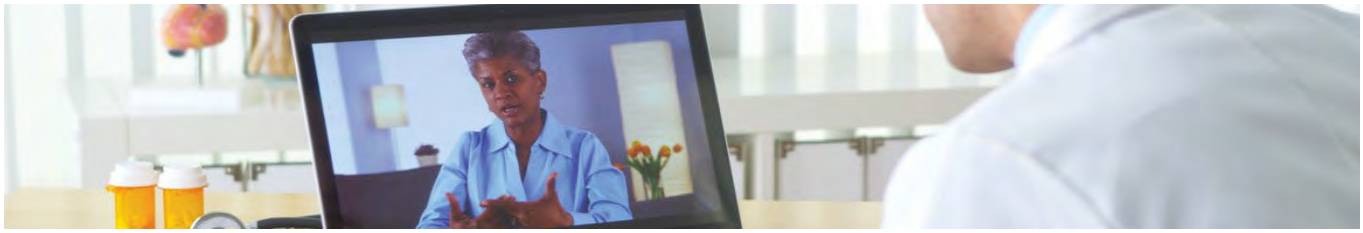
Download our mobile app today on a smartphone or tablet at App Store or Google Play.

Traveling? Kaiser members now have access to **Cigna's PPO Network** of providers and facilities. For more information, visit Kaiser's Care while traveling site, where you can get more information on how to get care while traveling. You may also call Kaiser's Home Travel Line at (951) 268- 3900 or visit kp.org/travel.

These services are for non-emergency health issues only.
If you are experiencing a life-threatening emergency, please call 911.

Medical

WELLNESS TOOLS



ANTHEM BLUE CROSS MEMBERS

Your emotional health is an important part of your overall health. With Emotional Well- being Resources, administered by **Learn to Live**, you can receive support to help you and your household live your happiest, healthiest lives.

Learn to Live has digital tools available anytime, anywhere 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.

Change your mind. Change your life

Take a quick assessment to find the program that's right for you. To access Anthem's Emotional Well-being Resources:

- Log in to anthem.com/ca
- Go to My Health Dashboard, choose Programs, and
- Select Emotional Well-being Resources

KAISER PERMANENTE MEMBERS

Everyone needs support for total health — mind, body, and spirit. Digital tools can help you navigate life's challenges, make small changes that improve sleep, mood, and more, or simply support an overall sense of well-being.

- Thoroughly evaluated by Kaiser Permanente clinicians
- Easy to use and proven effective
- Safe and confidential

Explore activities and techniques that can benefit anyone — either as self-guided self-care or complements to clinical support. They're not intended to replace treatment or advice, but they can help you build resilience, set goals, and take meaningful steps toward becoming a healthier, happier you.

Calm

The #1 app for meditation and sleep. Choose from hundreds of activities to build mental resilience, reduce stress, and experience better rest.

myStrength
The health club for your mind™

Evidence-based programs to help members set mental health goals, track progress, and get support managing depression, anxiety, and more.

ginger

1- on- emotional support coaching and self-care activities for many common challenges like anxiety, stress, and relationship issues. Adult members can use text-based coaching for 90 days per year

Adult Kaiser members can download these popular apps at kp.org/selfcareapps.

The Calm app is not available to KP Washington members at this time. myStrength is a wholly owned subsidiary of Livongo Health, Inc.

Medical

MEMBER DISCOUNTS

Anthem BlueCross

Saving money is good. Saving money on things that are good for you — that's even better. With SpecialOffers, you can get discounts on products and services that help promote better health and well-being. It's just one of the perks of being a member.

Vision, hearing, and dental

Glasses.com™ and **1-800-CONTACTS —** Get the latest, brand-name frames for just a fraction of the cost at typical retailers — every day. Plus, you get an additional $20 off orders of $100 or more, free shipping and free returns.

Premier LASIK — Save $800 on LASIK when you choose any 'featured' Premier LASIK Network provider. Save 15% with all other in-network providers

Amplifon — Get 25% off, plus an extra $50 off one hearing aid: $125 off two.

Fitness and health

Active&Fit Direct – Active&Fit Direct allows you to choose from 9,000+ participating fitness centers nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes). Offered through American Specialty Health Fitness, Inc.

ChooseHealthy — Discounts are available on acupuncture, chiropractic, massage, podiatry, physical therapy, and nutritional services. You also have discounts on fitness equipment, wearable tracker,s and health products, such as vitamins and nutrition bars.

Family and home

Nationwide Pet Insurance — Receive an automatic 5% discount when you enroll through your company or organization. Save up to 15% when you enroll multiple pets.

To find the discounts that are available to you as an Anthem member, log in to anthem.com/ca and select **Discounts.**

KAISER PERMANENTE

There are many approaches to supporting good health. In addition to your doctor's care, Kaiser Permanente members can access a variety of complementary and alternative care resources to help you get active and stay healthy.

With the ChooseHealthy program, you may pay less for many specialty health and fitness services including acupuncture, chiropractic care, fitness center access, and massage therapy.

You also get access to online wellness information, activity tracking, and other tools, and a health and wellness library at no additional cost.

Acupuncture, Chiropractic Services & Massage Therapy

Get 25% off the contracted provider's standard fees when you make an appointment through the ChooseHealthy program. You don't need a referral from your doctor, and you can see a participating provider as many times as you want.

Just go to kp.org/choosehealthy to select a provider and set an appointment. Don't forget to show them your Kaiser ID card!

The **Active&Fit Direct** program offers access to fitness center memberships for just $28 a month, plus a $28 enrollment fee. Choose from more than 9,000 participating fitness centers and instructor-led classes nationwide and start exercising today.

To find a participating fitness center near you, go to kp.org/choosehealthy, select your area, click the "Choosehealthy" link, then click "Learn More" in the Active and Fit Center.

For more information about ChooseHealthy offerings:

- Call **1-877-335-2746**, Monday through Friday from 5 a.m. to 6 p.m. Pacific time
- Visit **kp.org/choosehealthy**

For more in-depth information on your benefits, please visit www.4cd.edu/hr/benefits

Prescription 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.

If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. Here are the prescription drug plans that are offered with our Anthem Blue Cross and Kaiser Permanente medical plans.

For your carrier's formulary drug list, please visit https://www11.anthem.com/ca/pharmacyinformation or www.KP.org/formulary

	Anthem Blue Cross EPO Plan	Kaiser Permanente HMO Plan
	In-Network[1]	**In-Network**
Retail Pharmacy		
Generic	$10 copay	$10 copay
Preferred Brand	$20 copay	$20 copay
Non-preferred Brand	$20 copay	-
Supply Limit	30 days	100 days
Mail Order		
Generic	$10 copay	$10 copay
Preferred Brand	$20 copay	$20 copay
Non-preferred Brand	$20 copay	-
Supply Limit	90 days	100 days

[1] If purchasing from **non-participating pharmacies,** member pays the retail pharmacy copay plus 50% of the remaining Rx maximum allowed amount and costs in excess of the prescription drug maximum allowed up to $250 per Rx.

WANT MORE SAVINGS ON YOUR PRESCRIPTIONS?

Anthem Blue Cross and IngenioRX offer 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.

HOW TO GET STARTED:

1. Contact your doctor to ask for a script. Make sure that your doctor signs and dates it.
2. Download the IngenioRx Home Delivery Order Form from www.4cd.edu/hr/benefits.
3. Once completed, attach your doctor's script, and mail them to: **IngenioRx Home Delivery**
   PO BOX 94467
   Palatine, IL 60094-4467

Dental – Full-Time Employees

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Contra Costa Community College District provides you with an incentive dental plan through Delta Dental.

	Delta Dental PPO	Delta Dental Premier[1]
Calendar Year Deductible	$0 per individual $0 per family	$0 per individual $0 per family
Annual Plan Maximum	$2,100 per individual	$2,000 per individual
Waiting Period	None	None
Diagnostic and Preventive Exams, 2 cleanings & x-rays	Plan pays 70-100%	Plan pays 70-100%
Basic Services Fillings, simple tooth extractions and sealants	Plan pays 70-100%	Plan pays 70-100%
Endodontics (root canals)	Plan pays 70-100%	Plan pays 70-100%
Periodontics (Gum treatments)	Plan pays 70-100%	Plan pays 70-100%
Oral Surgery	Plan pays 70-100%	Plan pays 70-100%
Major Services Crowns, inlays, onlays, and cast restorations	Plan pays 70-100%	Plan pays 70-100%
Prosthodontics Bridges and dentures	Plan pays 50%	Plan pays 50%
Orthodontic Services (Adults and dependent children up to age 26)		
Orthodontia	Plan pays 50%	
Lifetime Maximum	$2,000	

1 Out of network dentists may directly bill the patient for the difference between Delta Dental's payment and their actual charge for services (balance billing).

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 – Part-Time Faculty

Regular visits to your dentists can protect more than your smile they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Contra Costa Community College District provides you with a comprehensive coverage through Delta Dental.

	Delta Dental PPO
Calendar Year Deductible	$50 per individual $150 per family
Annual Plan Maximum	$1,000 per individual
Waiting Period	None
Diagnostic and Preventive Exams, 2 cleanings & x-rays	Plan pays 100%
Basic Services Fillings, simple tooth extractions and sealants	Plan pays 80%
Endodontics (root canals)	Plan pays 80%
Periodontics (Gum treatments)	Plan pays 80%
Oral Surgery	Plan pays 80%
Major Services Crowns, inlays, onlays, and cast restorations	Plan pays 50%
Prosthodontics Bridges and dentures	Plan pays 50%
Orthodontic Services (Dependent children only)	
Orthodontia	Plan pays 50%
Lifetime Maximum	$1,000

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 – Part-Time Faculty

Regular visits to your dentists can protect more than your smile they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Contra Costa Community College District provides you with a comprehensive coverage through Delta Dental Insurance Company.

	Delta Care DHMO
	Copay
Diagnostic & Preventive	
Office Visit	$0
Teeth Cleaning – 1 per 6 months X-rays	$0 $0
Sealants – per tooth	$10
Restorative	
Amalgam filling – 1-3 surfaces	$0
Composite filling – 1-3 surfaces	$0
Periodontics	
Scaling and root planning – per quad	$50
Gingivectomy	$130
Osseus Surgery	$300
Endodontics	
Pulp Cap	$0
Therapeutic Pulpotomy	$25
Root Canal Therapy	$95 - $335
Prosthodontics Immediate –	
Upper or lower Complete –	$305
Upper or lower	$285
Partial denture – Upper or lower	$315
Crown and Bridge	
Inlay/onlay	$145 - $190
Crown – Porcelain/ceramic substrate	$355
Crown – Porcelain fused with high noble metal	$355
Crown – Full cast high noble metal	$355
Oral Surgery	
Extractions – Impacted tooth: soft tissue	$55
Extractions – Impacted tooth: partial bony	$75
Extractions – Impacted tooth: full bony	$95
Orthodontic Services	
Adult	$2,100
Dependent Child (up to 26)	$1,900

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

DELTA DENTAL MEMBER DISCOUNTS

While your oral health remains the top priority, Delta Dental also cares about the bigger picture — your overall well- being[1]. That's why dental members now have access to preferred pricing on hearing aid and LASIK services through Amplifon Hearing Health Care and QualSight[2].

Access to sizeable savings	62% average savings off retail hearing aid pricing,[3] backed by a best price guarantee[4]	40-50% off the national average price of Traditional LASIK[5]
Convenient locations	Broad nationwide network of providers	1,000+ LASIK locations[6]
Quality care and products	Access to the nation's leading brands featuring the latest hearing aid technology	Experienced LASIK surgeons who have collectively performed 6.5+ million procedures[6]
Customized support	Amplifon acts as your personal concierge at every step, from appointment scheduling and hearing aid selection to coordinating follow-up care.	A QualSight care manager will walk you through the program, coordinate care and help select the right physician and procedure.
For more information	Amplifon's hearing aid discounts, visit www.amplifonusa.com/deltadentalins or call 1-888-779-1429. Patient Care Advocate will help you find a hearing care provider near you.	QualSight's LASIK discounts, visit www.qualsight.com/-delta-dental or call 1-855-248-2020. A care manager will explain the program and answer any questions.

[1]Delta Dental of California, Delta Dental Insurance Company, Delta Dental of Pennsylvania, Delta Dental of New York, Inc. and our affiliated enterprise companies.

[2] The Vision Corrective Services and hearing health care services are not insured benefits. Delta Dental makes the Vision Corrective Services program available to enrollees to provide access to the preferred pricing for LASIK surgery. Delta Dental makes the hearing health care services program available to enrollees to provide access to the preferred pricing for hearing aids and other hearing health services.

[3] Amplifon Hearing Health Care utilization database, January-December 2018. Discounts or savings may vary by manufacturer and technology level of the hearing aid device.

[4] Amplifon offers a price match on most hearing devices; some exclusions apply. Not available where prohibited by law. Visit www.amplifonusa.com/deltadentalins or call 1-888-779-1429 for more details.

[5] Refractive Quarterly Update, Market Scope LLC, November 2018. Discounts or savings may vary by provider.

[6] QualSight provider file, February 2019

Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions. We offer you a vision plan through Vision Service Plan.

	VSP Signature
Exam and glasses copay	$10
Frames	$170 Retail Allowance $190 allowance on featured frame brands like Anne Klein, Bebe, ck Calvin Klein, Flexon, Lacoste, Nine West, and more 20% savings on the amount over your allowance
Diabetic Eyecare Plus Program[1]	$20
Lenses	
Single Vision Lenses	Covered in Full
Lined Bifocal Lenses	Covered in Full
Lined trifocal Lenses	Covered in Full
Lens Options	
Tints/Photochromic Lenses	Covered in Full
Progressive Lenses	Covered in Full
UV Protection	Covered in Full
Contact Lens (in lieu of glasses)	
Elective	$170 Allowance Covered
Medically Necessary	in Full
Computer Vision Care (Employee-only coverage)	
Exam	$10 for exam and glasses
Frame ($80 allowance)	Covered in Full Covered
Lenses	in Full
Frequency	
Exam	12 months
Lenses	12 months
Contact Lenses	12 months
Frames	
Regular	12 months
Computer	24 months

[1]DIABETIC EYECARE PLUS PROGRAM

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

The information in this booklet is a general outline of the benefits offered under the Contra Costa Community College District benefits program. This booklet may not include all relevant imitations and conditions. Specific details and limitations are provided in the plan documents, which may include a Summary of Plan Description (SPD), Evidence of Coverage (EOC), and/or insurance policies. The plan documents contain relevant plan provisions. If the information in this booklet differs from the plan documents, the plan documents will prevail.

Vision

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. **Services include:**

- medical follow-up exams,
- visual field and acuity tests,
- specialized screenings and diagnostic tests,
- diagnostic imaging of the retina and optic nerve,
- retinal screening for eligible members with diabetes.

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.

VSP EXCLUSIVE MEMBER DISCOUNTS

EXTRA SAVINGS ON GLASSES & SUNGLASSES

- Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details.
- 30% savings 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

- No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam

LASER VISION CORRECTION

- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities
- After surgery, 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:

- One year of follow-up visits for fitting, adjustments, and cleanings
- A 60-day trial
- 3-year manufacturer's warranty for repairs and one-time loss and damage
- 80 free batteries per hearing aid for non-rechargeable models

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp Or, call 877.396.7194 with questions.

Life and Long-Term Disability Insurance

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.
- **Evidence of Insurability form**: If you want to increase coverage, you will need to fill out and submit an EOI form that Sun Life must approve.
- **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.

BASIC LIFE (District Paid)

Full-Time Employees	$50,000

ADDITIONAL LIFE INSURANCE (Employee Paid)

Employee Amount of Coverage	Cost Per Month
$50,000	$16.90
$100,000	$33.80
In excess of $100,000	Varies
Maximum Coverage	Can be up to 5 times the salary or $400,000, whichever is greater

Evidence of Insurability (EOI) form will be required for coverage in excess of $150,000.

Dependents[1]

Spouse and child under 26	$ 5,000
Cost:	$1.32

[1] Amount of dependent life insurance cannot exceed 50% of employee's coverage

LONG TERM DISABILITY (District Paid)

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

If you qualify, long-term disability benefits begin after short-term disability benefits end.

DO YOU NEED TO UPDATE?

Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary unless they sign a waiver.

Elimination Period	60 days
Monthly Benefit Amount	Plan pays 66.67% of Total Monthly earnings
Minimum Monthly Benefit	$100 or 10% of gross monthly benefit, whichever is greater
Maximum Monthly Benefit	$9,000

Sunlife Additional Services

assist america®

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.

Employee Assistance Program

AVAILABLE TO MONTHLY CLASSIFIED, FULL-TIME FACULTY AND MANAGEMENT, SUPERVISORS, AND CONFIDENTIAL EMPLOYEES ONLY

We are Here to Help

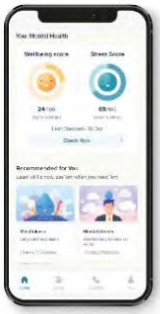
Employee Assistance Program (EAP) benefits are available to all employees and their families at NO COST to you. The EAP offers confidential advice, support, and practical solutions to real-life issues. You can access these confidential services by calling the toll-free number and speaking with our care team or accessing online. All services are confidential and in accordance with professional ethics and federal and state laws. These services are available by Claremont.

You and those family members living in your household are covered for up to **ten (10)** face-to-face or telephonic consultations for clinical counseling sessions per issue, per benefit year. If it is determined that more than ten sessions are needed for your specific situation, the EAP will help coordinate your needs under your medical plan.

Your EAP provides a wide range of work-life services to help you manage a variety of challenges.

- Confidential Therapy
- 25-hour Crisis Help
- Online Peer Support Groups
- Financial Help
- Legal services
- Child & Parenting Services
- Adult & eldercare Services
- Personal Advantage

EAP Plus Program – Uprise Health app. Here to Help, Anytime, Anywhere.



- Bite-sized training is available from your desktop or mobile app.
- Access is confidential. Take the assessment and check your wellbeing score.
- Get personalized recommendations.
- Skills training to develop your resilience, stress management, and mental fitness.
- Free sessions with a coach via phone or unlimited asynchronous chat.
- Visit claremonteap.com and select the Digital EAP tab to get started.
- Download the Uprise Health app.
- Create an account with your email. Your Employer Code is “CONTRACOSTA”.

Call (800) 834-3773 24/7 It’s ok to ask for help

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. And reimbursements from your FSA accounts are tax-free. The catch is that you have to use the money in your account by our plan year's end. Otherwise, that money is lost, so plan carefully. **Register at www.naviabenefits.com. Access Code is YDC.**

HEALTHCARE SPENDING ACCOUNT

This account will reimburse you with pre-tax dollars for qualified out-of-pocket healthcare expenses not covered under your healthcare plan. You may also use this this fund for medical-related expenses include out-of-pocket money for copays or deductibles for medical, dental and vision services.

For a comprehensive list of eligible expenses, please refer to the Flexible Spending Account Handbook posted on www.4cd.edu/hr/benefits.

The maximum amount you may contribute to the Healthcare Spending Account for the Plan Year is **$3,050** per person per plan. There is no household maximum as with the Dependent Care Spending Account. Therefore, if your spouse's employer also offers an FSA, he/she could also enroll up to the maximum amount.

PLAN ACCORDINGLY!
Make sure that you utilize your funds within the calendar year. Any unused funds over $500 remaining in your account at the end of the Plan year will be turned over to the District. The last day to submit claims is March 31st of the following calendar year

DEPENDENT CARE SPENDING ACCOUNT

The maximum amount you may contribute to the Dependent Care Spending Account is $5,000 each calendar year or $2,500 each calendar year if you are married but file separate tax returns. This account will reimburse you with pre-tax dollars for daycare expenses for your child(ren) and other qualifying dependents. These include expenses for childcare or dependent adult care for a member of your household.

Eligible Dependents Include:

- Children under the age of 13 who qualify as dependents on your Federal tax return; and
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your Federal tax return.

For a comprehensive list of eligible expenses, please visit www.naviabenefits.com.

You need to re-enroll in this program each year.

TRANSPORTATION SAVINGS ACCOUNT

Do you have out-of-pocket commuting expenses for public transportation or for worksite parking? If so, you can save on taxes by enrolling in our Transportation Savings Account (also known as a Section 132 plan.)

A Transportation Savings 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.

Here are the maximum amounts of money you can set aside:

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

These amounts are evaluated annually by the IRS and are subject to change.

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. www.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.

Cost of Coverage

Full-Time Permanent Employees[1]

Contra Costa Community College District Active Employee Benefit Rates Fiscal Year 2023 - 2024						
Benefit Type	**Coverage Type**	**Total Monthly Premium**	***Local 1 and UF 6%**	**District Rate**	***Unrep. 12%**	**District Rate**
Kaiser (HMO)	Single	$ 864.84	**$ 51.89**	$ 812.95	**$ 103.78**	$ 761.06
	2-Party	$ 1,729.66	**$ 103.78**	$ 1,625.88	**$ 207.56**	$ 1,522.10
	Family	$ 2,447.48	**$ 146.85**	$ 2,300.63	**$ 293.70**	$ 2,153.78
Blue Cross (EPO)	Single	$ 1,462.38	**$ 87.74**	$ 1,374.64	**$ 175.49**	$ 1,286.89
	2-Party	$ 3,070.97	**$ 184.26**	$ 2,886.71	**$ 368.52**	$ 2,702.45
	Family	$ 4,387.08	**$ 263.22**	$ 4,123.86	**$ 526.45**	$ 3,860.63
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	*In Lieu of Medical Plan*	$ 600.00	$ -	$ 600.00	$ -	$ 600.00
Sun Life	Basic ($50,000)	$ 6.75	$ -	$ 6.75	$ -	$ 6.75
	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**	$ -

[1]**Classified Employees who are less than < .100 FTE, please contact Renita Mack in Human Resources at (925) 229-6855 or Clarissa Cadena (925) 229-6863.**

Cost of Coverage

Part-Time Faculty

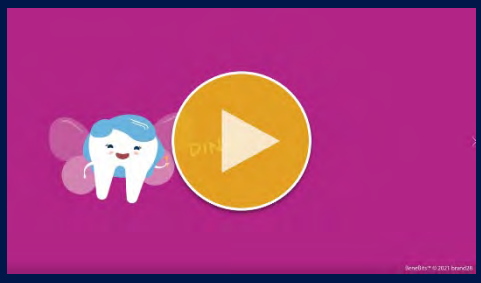
Benefit Plan	Coverage Type	Total Monthly Premium	30-30% - Average Load for Previous Academic Year (Fall 2022 & Spring 2023)		40-59% - Average Load for Previous Academic Year (Fall 2022 & Spring 2023)		60% or Greater Average Load for Previous Academic Year (Fall 2022 & Spring 2023)	
			Instructor Pays 60%	District Pays 40%	Instructor Pays 50%	District Pays 50%	Instructor Pays 25%	District Pays 75%
Kaiser (HMO)	Employee	$864.84	**$518.90**	$345.94	**$432.42**	$432.42	**$216.21**	$648.63
	Employee + 1	$1,729.66	**$1,037.80**	$691.86	**$864.83**	$864.83	**$432.42**	$1,297.25
	Employee + 2 or more	$2,447.48	**$1,468.49**	$978.99	**$1,223.74**	$1,223.74	**$611.87**	$1,835.61
Anthem (EPO)	Employee	$1,462.38	**$877.43**	$584.95	**$731.19**	$731.19	**$365.60**	$1,096.79
	Employee + 1	$3,070.97	**$1,842.58**	$1,228.39	**$1,535.49**	$1,535.49	**$767.74**	$2,303.23
	Employee + 2 or more	$4,387.08	**$2,632.25**	$1,754.83	**$2,193.54**	$2,193.54	**$1,096.77**	$3,290.31
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 *Instructor Pays Full Premium*	Employee	$18.97	**$11.38**	$7.59	**$9.49**	$9.49	**$4.74**	$14.23
	Employee + 1	$37.94	**$22.76**	$15.18	**$18.97**	$18.97	**$9.49**	$28.46
	Employee + 2 or more	$61.10	**$36.66**	$24.44	**$30.55**	$30.55	**$15.28**	$45.83

Get Educated Virtually!

Get help with your benefits however you feel most comfortable. Below is a list of fun, educational videos where you can learn about different topics that will help you better understand your benefits!

All About HMO Plans

All About PPO Plans



Dental

Flexible Spending Accounts FSA

What's a Qualifying Life Event

Virtual Healthcare

For Assistance

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

Carrier	Phone Number	Website	Policy/Group #
Anthem Blue Cross Member Services	(855) 333-5730	www.anthem.com/ca	277996
Anthem Prescription	(800) 700-2541	www.anthem.com/ca	277996
Anthem Nurseline	(800) 337-4770	www.anthem.com/ca	277996
Anthem Blue Cross – Telemedicine (LiveHealth)	(844) 784-8409 Medical (844) 784-8409 Psychology (888) 548-3432 Psychiatry	www.livehealthonline.com	277996
Kaiser Permanente Member Services	(800) 464-4000	www.kp.org	162
Kaiser RX Formulary	(800) 464-4000	www.KP.org/formulary	162
Kaiser Video Visits	Kaiser members need to schedule video visits with their doctor's office.		
Delta Dental Full-time Faculty			
PPO	(866) 499-3001	www.deltadentalins.com	00621
Delta Dental Part-Time Faculty			
PPO	(800) 765-6003	www.deltadentalins.com	00965 (PPO)
DHMO	(800) 422-4234	www.deltadentalins.com	71691 (DHMO)
VSP Vision Service Plan	(800) 877-7195	www.vsp.com	104331
Sun Life Financial	(800) 247-6875	www.sunlife.com	80816
Claremont Employee Assistance Program	(800) 834-3773	claremonteap.com	Access code: CONTRACOSTA
Navia Benefit Solutions (FSA)	(866) 897-1996	www.naviabenefits.com	YDC
Deferred Compensation	(925) 229-6860	kmyers@4cd.edu	N/A

4CD Employee Benefits Team

Clarissa Cadena
Employee Benefits Specialist
Phone: (925) 229-6863
Email: ccadena@4cd.edu

Renita Mack
Benefits Analyst
Phone: (925) 229-6855
Email: rmack@4cd.edu

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out- of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations, and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer, and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

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

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Mandatory Notices

(No Action Needed)

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

The Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we periodically remind you of your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting Human Resources.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in a Contra Costa Community College District health plan for 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 a Contra Costa Community College District 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 your dependent becomes 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 rights, you may add the dependent to your current coverage or change to another health plan.

NOTICE OF CHOICE OF PROVIDERS

HMO plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, your carrier will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier directly.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights to coverage to be provided in a manner determined in consultation with the attending Physician 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 are subject to the same deductible and co- payments applicable to other medical and surgical benefits provided under our plans. If you would like more information on WHCRA benefits, call your plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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.

AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by Contra Costa Community College District represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Contra Costa Community College District offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by Contra Costa Community College District are available on www.4cd.edu/hr/benefits. .

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 2023

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:
$97,000 or less	$194,000 or less	$164.90	Your plan premium
above $97,000 up to $123,000	above $194,000 up to $246,000	$230.80	$12.20 + your plan premium
above $123,000 up to $153,000	above $246,000 up to $306,000	$329.70	$31.50 + your plan premium
above $153,000 up to $183,000	above $306,000 up to $366,000	$428.60	$50.70 + your plan premium
above $183,000 and less than $500,000	above $366,000 and less than $750,000	$527.50	$70.00 + your plan premium
$500,000 or above	$750,000 and above	$560.60	$76.40 + 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:
$97,000 or less	$164.90	Your plan premium
above $97,000 and less than $403,000	$527.50	$70.00 + your plan premium
$403,000 and above	$560.50	$76.40 + your plan premium

Source: Medicare.Gov

MEDICARE PART D

Important Notice from Contra Costa Community College District About Your Prescription Drug Coverage and Medicare

This notice is to all employees, retirees and COBRA participants who are Medicare-eligible and on a District medical plan. If you are not Medicare-eligible or not on a District medical plan you may ignore this notice. This notice is to inform Medicare- eligible employees, retirees and COBRA participants that your current prescription drug benefit program through Contra Costa Community College District provides "creditable coverage," as defined below and to let you know that if you ever lose your current District prescription drug coverage, through no fault of your own, you will then be eligible for a two-month special enrollment period to enroll in a Part D plan. It also includes answers to questions you may have regarding your current prescription drug program and how it relates to Medicare Part D coverage.

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 our Kaiser Permanente Senior Advantage and Anthem Medicare Preferred PPO 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.

THIS IS YOUR NOTICE OF CREDITABLE COVERAGE. Be sure to read it carefully and keep it in a safe place where you can find it. If you lose this notice and need another copy, please call Reed Rawlinson at 925-229-6853, or request a copy in writing from Reed Rawlinson, 500 Court Street, Martinez, CA 94553. Updated versions of this notice will be sent annually and you will be informed if the District ever loses its creditable coverage status.

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 through 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 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 Contra Costa Community College District is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Contra Costa Community College District prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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 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 office 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 changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call (800) MEDICARE or (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 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: December 1, 2023

Plan Sponsor: Contra Costa Community College District

Administrator: Renita Mack

Address: 500 Court Street, Martinez, CA 94553

Telephone: If you have questions, please contact Renita Mack at 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.

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

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

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

  All employees. Eligible employees are:

  ☐

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☐ We do offer coverage. Eligible dependents are:

  ☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)

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

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

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

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

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

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

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

☐ Employer won't offer health coverage

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

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

General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

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

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

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

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

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

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

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

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

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

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

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

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

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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

Contra Costa Community College District

pathways to success

Rev. 6/28/2023