Coast Colleges

BENEFITS OFFICE

2022-2023 Employee Benefits Overview

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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 Notice beginning on page 29 for more details.

We’ve Got You Covered

At Coast Community College District, we believe that you, our employees, are our most important asset. Helping you and your family achieve and maintain good health—physical, emotional and financial—is the reason Coast Community College 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. A list of plan contacts is provided at the back of this summary.

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, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid and should this guide differ from plan documents, the plan documents will always prevail.

The benefits in this summary are effective:

October 1, 2022 - September 30, 2023

Enrollment

INITAL ENROLLMENT PERIOD

Coverage for new employees begins on the first of the month following date of hire. However, coverage will be effective on the first day of employment, if the employment date is the first of the month and it is a scheduled workday for that employee.

Please note that if you fail to enroll within 31 days after completion of the waiting period, you cannot enroll until the next open enrollment period unless you experience a qualifying event (see below).

ANNUAL OPEN ENROLLMENT PERIOD

Open enrollment is generally held every August and plan changes are effective October 1st/ or January 1st. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying event. During open enrollment, you can:

- Transfer to a different medical plan
- Add or remove eligible family members
- Enroll or re-enroll in a Health Flexible Spending Account and/or a Dependent Day Care Flexible Spending Account
- Add or remove coverage in other optional plans such as Voya Optional Life Insurance, Basic Dependent Life, MetLife Legal (Hyatt Legal), American Fidelity plans.

OTHER ENROLLMENT OPPORTUNITIES

Other than during the annual "open enrollment" period, you may not change your coverage unless you qualify for a "special enrollment." If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of coverage. Changes must be made within 31 days of the event date, and these changes, 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 – MUST NOTIFY BENEFITS – EX-SPOUSE MUST BE DROPPED FROM COVERAGE

Make sure to notify the Benefits Department – Human Resources right away if you have a qualifying event and need to make a change (add or drop) to your coverage election. Remember, life changes must be made within 31 days of the event date. After the specified period, you may not be able to make any changes in your coverage until the next annual open enrollment period.

Open Enrollment Platform AFenroll

HOW TO ENROLL

How to Login:

1. To access the online enrollment site, go to AFenroll.com/Enroll
2. At the login screen, you will enter the site using the following information:
    a. Type in your user ID: Your Social Security Number (SSN) OR your Employee ID
    b. Type in your PIN: The last four digits of your SSN and last two of your birth year.
    (For example, for SSN 123-45-6789 and birth year 1974, you would type in 678974).
3. Click the 'Log On' button.

Two-Factor Authentication:

As an added security measure, the AFEnroll Platform has implemented Two-Factor Authentication. When you enroll, you will be prompted to provide a verification code. You may select an option to receive the verification code via email or text message.

Completing your Enrollment:

You **must** select CONFIRM to complete your enrollment. If you do not do so, your elections will not be processed for the upcoming plan year.

HELPFUL TIPS

Log Out: If you leave the site in the middle of the process, click the 'Log Out' button to save your selections.

Print Confirmation: Be sure to print your confirmation. Once you confirm your enrollment, you may click on the confirmation link at the bottom of the 'Sign/Submit Complete' to print your confirmation statement.

Re-Enter/Make Changes: You may re-enter the enrollment site (including to 'View Only' your original selections) to make changes at any time during your enrollment period. Please note: Before you exit the system, you must re-confirm with your PIN or your enrollment will not be valid.

Opting Out: If you choose not to select benefits, you must enter each product module and make that choice.

Required: Social Security Numbers and Dates of Birth are required for all employees.

Signature: You will use your PIN to confirm applications and your enrollment confirmation.

Who Can You Cover?

WHO IS ELIGIBLE?

The following classes are eligible for the benefits outlined in this overview:

- **Active Full-Time Employees:** Faculty Employees, Classified Employees and Educational Administrators who are regularly scheduled to work from 75% through 100% of a full-time schedule.
- **Active Part-Time Employees:** Faculty Employees, Classified Employees and Educational Administrators regularly scheduled to work from 50% through 74% of a full-time schedule.
- **Active Part-Time Faculty:** Part-Time Faculty maintaining a minimum of 7.5 to 10 lecture hour equivalents by the third Monday of the Fall or Spring semester.

Faculty Employees are academic Contract Employees, Regular Employees, or Temporary Employees that provide services as an Instructor, Counselor, or Librarian and meet the minimum qualifications as established in Education Code.

Classified Employees are those in non-academic positions as defined in the Education Code.

Educational Administrators are academic managers as defined in the Education Code.

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 (a copy of the marriage certificate is required as proof).
- Your registered domestic partner (a copy of the Declaration of Domestic Partnership filed with the California Secretary of State is required as proof). Any premiums for your domestic partner paid for by Coast Community College District are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children—including biological, stepchildren, legally adopted, fostered, assigned under legal guardianship, or your domestic partner's children (a copy of the birth certificate is required as proof):
    - 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.

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.
- Common law spouse
- Children over age 26

What is the Employee Contribution Amount Towards Benefits?

The employee contribution amount towards benefits is as follows:

- **Active Full-Time Employees (75% FTE to 100% FTE):** All full-time employees contribute 0.8% of their annual salary towards their benefits. The amount is divided over 10-months and deducted from their monthly paycheck.
    - Full-Time Employees contribute an additional $500 per year to enroll 1 or more eligible dependents in District coverage. The amount is divided over 10-months and deducted from their monthly paycheck.
- **Active Part-Time Employees (50% FTE to 74% FTE):** All part-time employees contribute 50% of the plan premium towards their benefits. The amount is divided over 10-months and deducted from their monthly paycheck.
    - Part-Time Employees contribute an additional $500 per year to enroll 1 or more eligible dependents in District coverage. The amount is divided over 10-months and deducted from their monthly paycheck.
    - Plan premium rates are subject to change every year. Employees may view the CCCD Rate Sheets on the Benefits Navigator Site.
- **Active Part-Time Faculty (7.5 LHE to 10 LHE):** All part-time faculty employees contribute 50% of the plan premium towards their benefits. The amount is divided over 8-months and deducted from their monthly paycheck.
    - Part-Time Employees contribute an additional $500 per year to enroll 1 or more eligible dependents in District coverage. The amount is divided over 8-months and deducted from their monthly paycheck.
    - Plan premium rates are subject to change every year. Employees may view the CCCD Rate Sheets on the Benefits Navigator Site.

Pre-Tax or Post-Tax Payroll Deduction?

Under a Section 125 Plan, District employees can pay their employee contributions that are deducted from their paychecks with pre-tax or post-tax dollars. Employees can change their election of pre-tax / post-tax each year during open enrollment.

Pre-tax deductions reduce the amount of income that the employee must pay taxes on. Post-tax deductions have no effect on employee's taxable income.

Employees are encouraged to consult their financial advisor or tax preparer for guidance.

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 g 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.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER (PCP)

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

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.

AN APPLE A DAY

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

USING THE EMERGENCY ROOM

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time.

BE MED WISE!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

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. Coast Community College District gives you a choice between four medical plans: HealthNow (Anthem Blue Cross) PPO plan, Blue Shield Access + HMO, Blue Shield TRIO HMO, and Kaiser Permanente HMO.

Acupuncture and Chiropractic benefits are included in all of the District's medical plans.

You should carefully evaluate each plan. Choosing your medical plan depends on your specific health care needs, doctor preferences, budget, and the type of coverage you prefer.

BLUE SHIELD - ACCESS + HMO

The primary objective of a Health Maintenance Organization (HMO) plan is to offer you and your dependents quality coverage at a lower cost compared to a PPO plan. If you select the Blue Shield Access+ Full Network HMO, you must choose a primary care physician (PCP) and medical group, who will then coordinate your care through the carrier's Access+ HMO network of physicians and hospitals, resulting in cost savings for you. You will access most of your healthcare services through your PCP. When you do, you will pay just your copayment amount. You and your covered family members may choose to have the same or different PCPs.

Away From Home coverage is available upon qualifying. This program is for dependents who reside outside of California. Contact Blue Shield for additional information.

BLUE SHIELD - TRIO ACO HMO

The Trio ACO HMO provider network includes a subset of Independent Practice Associations (IPA), medical groups, and affiliated physicians from Blue Shield's Access+ HMO network. This network extends throughout 26 California counties, and this plan offers members access to a network of providers that includes all specialists and levels of care. Like the Access+ Full Network HMO plan, this plan requires members to select a primary care physician (PCP) and medical group to coordinate and direct their healthcare needs.

Similar to the Access + plan, Trio ACO members also have access to *Away From Home* coverage.

With the Trio ACO network, you have access to get brand and non-formulary medications.

For more information regarding either Blue Shield plan, visit the District's custom Blue Shield site:
Choose.BlueShieldCA.com/cccd.edu

KAISER PERMANENTE - HMO

The Kaiser HMO plan offers comprehensive coverage and the convenience of coordinated care within Kaiser. With this plan, you'll always know what your costs are. There are no deductibles or percentages to figure out; you will be responsible for the plan's set co-pay amounts. You can receive your care at any of the Kaiser locations, from a team of physician and nurses who want to see you at your best.

You can choose to receive care at any of the Kaiser medical facilities and affiliated physicians, depending on where you live. Whenever you go in to receive covered services, you'll only pay your copayment. You can choose your own personal primary care physician. If you need to see a specialist, your physician can easily refer you. For some specialties, you don't even need a referral to get an appointment.

For more information regarding the Kaiser Permanente Plan, visit the District's custom KP site:
My.KP.org/cccd/

HEALTHNOW (ANTHEM BLUE CROSS) - PPO

Preferred Provider Organization (PPO) plans are designed to provide you with choice and flexibility. They allow you to see any provider of your choice (in-network and out-of-network providers); however, by choosing to access care with a participating (in-network) provider, you will significantly reduce your out-of-pocket expenses. Participating providers are doctors, hospitals, pharmacies, and labs, etc., that participate in your carrier's network and have agreed to provide services at pre-negotiated reduced rates.

Employees who elect this plan will have access to Anthem's Network of Physicians and Facilities and Health Now will act as the plan's Third Party Administrator. HealthNow provides a variety of services – they process claims and make payments, audit hospital billings, coordinate very complicated health care arrangements, contract and maintain the PPO network listing – according to the specifications of the plan.

Medical

HEALTH ADVOCATES WITH HEALTHNOW

With HealthNow (the Administrator for the Anthem PPO plan) employees who enroll in the PPO will have access to a Health Advocate! This comes at no additional cost to you.

A Health Advocate provides confidential support to help you make sense of healthcare and take control of your health. When you have healthcare issues, it can greatly affect your health and financial wellbeing.

The Health Advocate experts make healthcare easier by supporting you and your eligible family members with a wide range of health and insurance-related issues, all through a single toll-free number.

Help with Medical Care

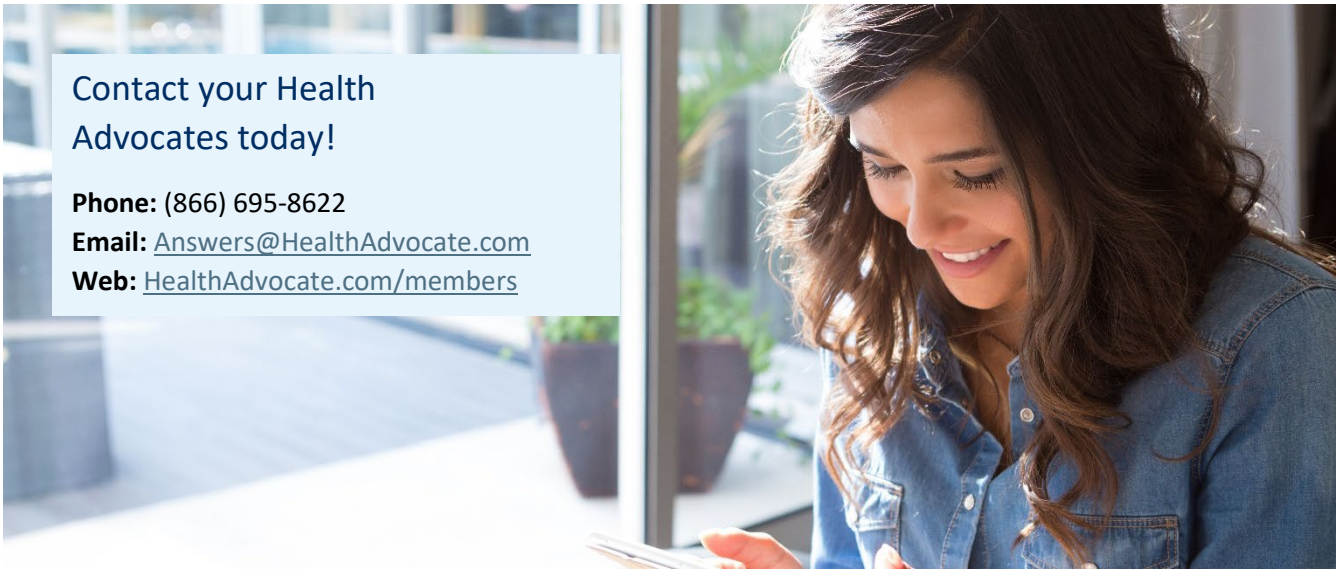
- Learn more about your diagnosis and treatment
- Get answers to your questions about medical conditions
- Find out the latest research and most advanced approaches to care
- Connect with the right in-network doctors and specialists, obtain second opinions

Help with Administrative Issues

- Get answers to benefits, eligibility and coverage questions
- Navigate through copays, coinsurance and cost-sharing
- Get assistance transferring medical records
- Untangle medical bills and resolve claims and billing issues

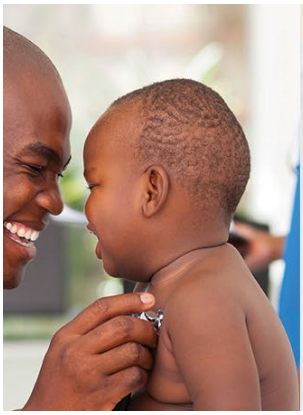
Help On the Go

- Get personalized help improving your health and saving on healthcare costs
- Instantly upload relevant documents and forms
- View tips on important consumer topics like ways to save money on your healthcare expenses or how to make the most of your medical visits
- Access trusted information on virtually any health topic like weight loss, pregnancy, first aid, chronic conditions and much more
- Get 24/7 live support from your Personal Health Advocate, who is standing by to answer your questions or help you with any of your healthcare and insurance-related issues



Medical

	Blue Shield TRIO HMO	Blue Shield Access + HMO	Kaiser Permanente HMO
	In-Network	In-Network	In-Network
Annual Out-of-Pocket Max			
Individual	$1,000	$2,000	$1,500
Family	$3,000	$6,000	$3,000
Office Visit			
Primary Provider	$5 copay	$5 copay	$5 copay
Specialist	$5 copay	$5 copay	$5 copay
Telehealth	Plan pays 100%	Plan pays 100%	Plan pays 100%
Preventive Services	Plan pays 100%	Plan pays 100%	$5 copay
Chiropractic Care	$10 (Limited to 30 visits combined with Acu)	$10 (Limited to 30 visits combined with Acu)	$15 (Limited to 30 visits combined with Acu)
Acupuncture Care	$10 (Limited to 30 visits combined with Chiro)	$10 (Limited to 30 visits combined with Chiro)	$15 (Limited to 30 visits combined with Chiro)
Lab and X-ray	Plan pays 100%	Plan pays 100%	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient Surgery	Plan pays 100%	Plan pays 100%	$5 copay
Urgent Care	$5 copay	$5 copay	$5 copay
Emergency Room	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$35 copay (waived if admitted)



Medical

	HealthNow PPO Anthem Network	
	In-Network	**Out-Of-Network***
Annual Deductible	$250 per individual $500 per family	$500 per individual $700 per family (combined with In-Network)
Annual Out-of-Pocket Max	$500 per individual $1,500 per family	$700 per individual $2,100 per family (combined with In-Network)
Office Visit		
Primary Provider	Plan pays 90%	Plan pays 75%
Specialist	Plan pays 90%	Plan pays 75%
Preventive Services	Plan pays 100% (deductible is waived)	Not covered
Chiropractic Care	Plan pays 90% (limited to 25 visits per incident per year)	Plan pays 75% (limited to 25 visits per incident per year)
Acupuncture Care	Plan pays 90% (limited to 25 visits per incident per year)	Plan pays 70% (limited to 25 visits per incident per year)
Lab and X-ray	Plan pays 90%	Plan pays 75%
Inpatient Hospitalization	Plan pays 90%	Plan pays 75%
Penalty deductibles	($200 per admission to a network hospital)	($400 per admission to a non-network hospital for non-emergency emissions and $600 per admission to a non-network hospital when precertification is not obtained. $200 for an outpatient weight control surgery when precertification is not obtained.)
Outpatient Surgery	Plan pays 90% (Precertification is required for outpatient weight control surgery)	Plan pays 75% (Precertification is required for outpatient weight control surgery)
Urgent Care	Plan pays 90%	Plan pays 75%
Emergency Room	$50 copay then plan pays 90% (copay waived if admitted)	$50 copay then plan pays 90% (copay waived if admitted)

*You will need to meet your out-of-network deductible and out-of-pocket maximum amounts for the year before your benefits kick in, even if you only see one provider that is out-of-network in that year.

Prescription Drugs

If you enroll in medical coverage, you will automatically receive coverage for 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.

PPO THROUGH ESI

Employees enrolled in the PPO plan will have prescription drug through Express Scripts (formerly known as Medco). You have access to a vast number of retail pharmacies which can be used if you are taking a drug on a short-term basis. Visit the Express Scripts website at Express-Scripts.com for a list of participating providers in your area. Use Express Scripts Mail Order Pharmacy if you take regular medications and need an extended fill. Mail order forms can also be found on the website.

Smart 90

Smart 90 is an ESI program that allows you to fill a 90 – day supply at either CVS or Walgreens. This is an alternative to the mail order program.

Vaccines through ESI

Members can now receive most vaccinations at your local pharmacy, not just your primary care physician.

Livongo Diabetes Management Program

This program is designed to make living with diabetes easier by providing members with a connected meter, unlimited strips, and coaching. Employees and their family members living with type 1 or type 2 diabetes will be able to join at no cost.

KAISER HMO

Kaiser members can fill their prescriptions in person at one of Kaiser's pharmacies or by completing a Kaiser Mail-order form and dropping it in the mail. Members should receive their prescriptions within two weeks. Mail-order forms can be found on the Kaiser website or at any Kaiser pharmacy. You may be able to order refills from a Kaiser pharmacy, via mail order or though Kaiser's website at KP.org/RxRefill.

BLUE SHIELD ACCESS + AND TRIO HMO

Blue Shield members can fill their prescriptions in person at one of Blue Shield's participating pharmacies. You may visit the Blue Shield website at BlueShieldCA.com for a list of participating providers in your area. Using the convenient mail service pharmacy can save you time and money. If you take a consistent dose of a covered maintenance drug for a chronic condition, such as diabetes or high blood pressure, you can received up to a 90-day supply through the mail service pharmacy with a reduced copayment. Call the mail service pharmacy at (866) 346-7200.

Prescription Drugs

	HealthNow PPO (through ESI)		Blue Shield TRIO HMO	Blue Shield Access+ HMO	Kaiser Permanente HMO
	In-Network	Out-Of-Network	In-Network	In-Network	In-Network
Separate Rx Annual Out-of-Pocket Limit	$6,350 per individual $12,200 per family		Included with medical annual out-of-pocket maximum	Included with medical annual out-of-pocket maximum	Included with medical annual out-of-pocket maximum
Pharmacy					
Generic	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay
Preferred Brand	$12 copay	$12 copay	$10 copay	$10 copay	$5 copay
Non-Preferred	$12 copay	$12 copay	$25 copay	N/A	N/A
Supply Limit	30 days	30 days	30 day	30 days	100 days
Mail Order					
Generic	$5 copay	$5 copay	$10	$10 copay	$5 copay
Preferred Brand	$12 copay	$12 copay	$20	$20 copay	$5 copay
Non-Preferred	$12 copay	$12 copay	**$50**	N/A	N/A
Supply Limit	90 days	90 days	90 days	90 days	100 days

Dental

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.

Coast Community College District provides you with a comprehensive coverage through Delta Dental of California.

	Delta Dental of California PPO[1]	
	In-Network[2]	Out-Of-Network[2]
Calendar Year Deductible	$50 per individual $100 per family	
Annual Plan Maximum	$3,200 per person	$3,000 (combined with in-network)
Diagnostic and Preventive (X-rays, Exams, and Cleanings)	Plan pays 80%	Plan pays 80%
Basic Services		
Fillings	Plan pays 80% after deductible	Plan pays 80% after deductible
Root Canals	Plan pays 80% after deductible	Plan pays 80% after deductible
Periodontics	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Services (Crowns, inlays, onlays and cast restorations)	Plan pays 80% after deductible	Plan pays 80% after deductible
Prosthodontics (Bridges, Dentures and implants)	Plan pays 80% after deductible	Plan pays 80% after deductible
Orthodontic Services		
Orthodontia	Plan pays 60%	Plan pays 60%
Lifetime Maximum	$3,000	$3,000 (combined with in-network)

1. Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.
2. Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

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).

	VSP	
	In-Network	**Out-Of-Network**
Examination		
Benefit	$5 copay	Plan pays up to $45
Optomap (Retinal Screening)	$0	Not Covered
Frequency	12 months	12 months
Eyeglass Lenses		
Single Vision Lens	Plan pays 100%	Plan pays up to $45
Bifocal Lens	Plan pays 100%	Plan pays up to $65
Trifocal Lens	Plan pays 100%	Plan pays up to $85
Frequency	12 months	12 months
Frames		
Benefit	$150 (20% discount on amount over allowance)	Plan pays up to $47
Frequency	24 months	24 months
Contacts		
Benefit (Elective)	Up to $120 (15% savings on a contact lens exam, fitting and evaluation)	Up to $105 (copay waived; instead of eyeglasses)
Frequency (in lieu of frames)	12 months	12 months

Extra Savings:

- Extra $20 to spend on featured from brands. Go to vsp.com/offers for details and information on additional discounts.
- 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 your VSP provider within 12 months of your last 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

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. The catch is that you have to use the money in your account by our plan year's end (December 31, 2023). Otherwise, that money is lost, so plan carefully. You must re-enroll in this program each year. American Fidelity Assurance administers this program.

FLEXIBLE SPENDING ACCOUNTS

IMPORTANT CONSIDERATIONS

- Expenses must be incurred between 1/1/2023 and 12/31/2023.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- You can keep (roll-over) up to $550 of unused money for use in the next plan year. Unused amounts above $550 will be lost, so it is very important that you plan carefully before making your election.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on the Coast Community College District health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.

HEALTHCARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to $2,850 this year.

DEPENDENT CARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to $5,000 per household (or $2,500 if married and filing separately) for eligible dependent care expenses for the year

Life and AD&D Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security. Life and Accidental Death & Dismemberment coverage is offered through Voya Financial.

BASIC EMPLOYEE LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the District for all benefits eligible employees working at least 50% to full-time.

Basic Life and AD&D Eligibility	
Class 1	Full-time faculty, full-time & part-time classified employees
Class 2	Board Members
Class 3	50% - 60% Part-Time Faculty Employees
Class 4	Retirees under age 70
Class 5	Deans and above
Class 6	Retired Deans and above
Class 7	Part-time faculty with 3.0+ Lecture Hour Equivalents and less than 7.5 Lecture Hour Equivalents

Taxes: Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit. You will see the value of the benefit included on your taxable income on your paycheck and W-2.

Basic Life Amount	
Class 1 & 4	1x annual salary to a minimum of $75,000 up to a maximum of $250,000 (rounded to the next lower multiple of $5,000)
Class 2	$100,000
Classes 3 & 7	$25,000
Class 5 & 6	1x annual salary to a minimum of $75,000 up to a maximum of $500,000 (rounded to the next lower multiple of $5,000)

Basic AD&D Amount	
Class 1	1x annual salary to a minimum of $75,000 up to a maximum of $250,000 (rounded to the next lower multiple of $5,000)
Class 2	$100,000
Classes 3 & 7	$25,000
Classes 4 & 6	Not Applicable
Class 5	1x annual salary to a minimum of $75,000 up to a maximum of $500,000 (rounded to the next lower multiple of $5,000)

Classes 1 & 5: Benefit amounts reduce to 50% of original coverage at age 70.

Classes 4 & 6: Benefits amount reduced to 0% at age 70

Life and AD&D Insurance

BASIC DEPENDENT LIFE

Basic Dependent Life (no AD&D) Insurance is also available to all eligible dependents in classes 1, 2, 4, 5 and 6 (not applicable to classes 3 & 7) and are 100% contributory. The amount of insurance for a dependent can be no more than 50% of your Basic Life Insurance Amount.

Basic Dependent Life Amount	
Spouse	$10,000
Dependent Child(ren)	$2,000

SUPPLEMENTAL EMPLOYEE AND DEPENDENT LIFE

Supplemental Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is also provided by Voya Financial and is available for all active Full-Time Faculty, Full-Time Classified, Board Members, and Deans and above. Employees must be enrolled in order to elect coverage for dependents.

	Supplemental Life Amount	Guaranteed issue:*
Employee	Increments of $10,000 from $20,000 to $500,000, not to exceed 5x your annual salary	Less than age 60: Up to the maximum guaranteed issue amount of $150,000 Age 60 or older: Up to the maximum guaranteed issue amount of $75,000
Spouse	Increments of $10,000 from $20,000 to $500,000, not to exceed 50% of the total amount of Employee Supplemental Life coverage	Up to the maximum guaranteed issue amount of $40,000
Children	$2,500 or $5,000 for infant 6 months to 19 years and full-time students less than 23 years; Children age 14 days but less than 6 months are covered for $500 or $1,000	Up to the maximum guaranteed issue amount of $5,000

*New hires and their dependents are offered guaranteed issue amounts of coverage without having to complete an Evidence of Insurability form (EOI).

Please note: Benefit amounts for employees and spouses/domestic partners reduce to 50% of original coverage at age 70.

Beneficiary Reminder: 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.

Evidence of Insurability: Depending on the amount of coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.

Life and AD&D Insurance

SUPPLEMENTAL EMPLOYEE AND DEPENDENT AD&D

Supplemental AD&D Insurance allows you to purchase additional accidental death and dismemberment insurance to protect your family's financial security.

Supplemental AD&D Amount	
Employee	Coverage is available in an amount equal to elected Employee Supplemental Life Insurance
Spouse	Not Applicable
Children	Not Applicable

Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability (STD) coverage pays you a benefit if you temporarily can't work because of an injury, illness, or maternity leave. This plan is 100% paid for by CCCD.

The plan is offered through Voya and administered by Coast Community College District.

Classified employees must satisfy a waiting period of 12 months permanency in order to be eligible for this benefit. Faculty employees must satisfy a waiting period of 3 months permanency in order to be eligible of this benefit.

	STD Benefit
Weekly Benefit Amount	50% of base salary
Benefits Begin After:	
Accident & Sickness	14 calendar days of disability
Maximum Payment Period	100 days (classified) of disability 110 days (faculty) of disability OR Until your sick leave is exhausted

COVERAGE DETAILS

Your sick pay must be exhausted and you must be receiving half-pay sick leave in order for your STD benefits to kick in. Your half-pay sick leave and the 50% of your income STD benefit will equate to 100% of your base salary.

Please note that other income such as summer assignments, intersession, or overtime do not apply towards your base salary. However, base salary does include shift differential and professional development stipend for classified staff in effect at the time of disability.

STD benefits are paid for faculty overload assignments; however, overload benefits will be exhausted at the end of the first semester in which the employee is disabled.

Please note: District employees are not entitled to disability benefits through the State of California.

CLAIMS PROCESS

Please notify the District Benefits office if you are going to be totally disabled for longer than 14 calendar days. The Benefits Office will provide claim forms for you and your physician to complete.

Disability Insurance

LONG-TERM DISABILITY INSURANCE

Long-Term Disability coverage pays you up to 60% of your salary at the time you were disabled 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 all paid leaves have been exhausted.

Coverage is provided by Voya Financial.

LTD Eligibility	
Class 1	Full-time faculty employees and educational administrators with 5+ years of service in the State Teachers Retirement System (CalSTRS)
Class 2	Full-time faculty employees and educational administrators with less than 5 years in the State Teachers Retirement System (CalSTRS)
Class 3	Full-time and part-time classified employees with the Public Employees' Retirement System (CalPERS)
Class 4	Full-time and part-time managers with Public Employees' Retirement System (CalPERS)

LTD Benefit	
Monthly Benefit Amount	Plan pays 60% of covered monthly earnings
Maximum Monthly Benefit	$5,000
Benefits Begin After:	
Classes 1 & 2	110 days of disability
Classes 3 & 4	100 days of disability
Maximum Payment Period:*	
Class 1	12 months
Classes 2, 3, & 4	Up to Social Security Normal Retirement Age

*Please note: The age at which the disability begins may affect the duration of the benefits.

CLAIMS PROCESS

Voya claim forms should be completed approximately 30 days prior to the completion of your 100 work day "Elimination Period". Your elimination period will be the later of 100 days or end/exhaustion of accumulated sick leave, salary continuance and STD. The application process is coordinated through the District Benefits Office.

Other Programs

Here are some other valuable programs that you are eligible to participate in:

WELLNESS PROGRAM

CCCD Wellness Program

The District Wellness Program sponsors classes and activities to identify personal risk factors in order to improve health. Health education, disease risk assessment and other wellness activities are being addressed by cancer screenings, blood pressure screenings, blood cholesterol measurements and diet and nutrition information. Be alert for Wellness Committee announcements of new activities and let the District Wellness Committee representatives know what you would like to see included in the District Wellness Program. Contact the District Benefits Office for a current list of Wellness Committee members.

EMPLOYEE ASSISTANCE PROGRAM

Anthem Blue Cross

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through Anthem Blue Cross can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it is free.

Our EAP with Anthem Blue Cross can arrange up to six free face-to-face or online visits via LiveHealth Online with licensed professionals for each issue you are facing.

Help is available 24/7, 365 days a year by calling (800) 999-7222. Other resources are available online at AnthemEAP.com, enter company code: **CCCD**. EAPs are available to ALL household members, even if they are not an eligible tax dependent.

LEGAL PROGRAM

MetLife

Do you have an attorney on retainer? Most people don't. Our Legal Program offers you access to legal advice and even representation for an affordable monthly premium of $17.50. Whether you need assistance reviewing a rental agreement, fighting a traffic ticket, creating a will, buying a house or navigating an IRS audit, Legal Insurance offers reputable legal assistance for you and your family. MetLife Legal provides coverage for this program which includes telephonic advice and office consultations on an unlimited number of matters. Sign up during open enrollment. For more information, contact MetLife at (800) 821-6400 or visit their website at Info.LegalPlans.com and enter password: GETLAW.

IRS SECTION 125

American Fidelity

The Section 125 Plan is a voluntary plan that is administered by American Fidelity Assurance Company. District employees are able to pay their medical premiums (for employee and dependent coverage), dental premiums, cancer plan premiums, and accident plan premiums with pre-tax dollars. These premiums include the 0.8% of your annual salary cost for your medical insurance and the $50 monthly cost for family medical coverage. Employees' premium contributions are automatically deducted from their salaries before taxes are taken out. Taxable income is reduced by the amount contributed, so employees pay less in taxes and have more take-home pay.

The open enrollment period for Section 125 Plans is August 1 to September 1 each year. The plan year is January 1 to December 31.

Other Programs

ACCIDENT ONLY PLAN

AF™ Limited Benefit Accident Only Insurance

Help offset unexpected medical expenses that can result from covered accidental injuries.

Whether you're a weekend warrior, have an active lifestyle, or just have a busy family, accidents can happen to you anytime, anywhere. Being prepared for the unexpected can make all the difference. This Limited Accident Only plan provides coverage for you and your family to help with those unforeseen accident expenses.

Benefits offered by American Fidelity. Learn more at AmericanFidelity.com/info/accident.

CANCER INSURANCE

AF™ Limited Benefit Individual Cancer Insurance

Cancer Insurance is designed to help ease the financial pressures of cancer treatment, so you can focus on recovery. Benefit payments are made directly to you, helping you pay for expenses like copayments, inpatient stays, and house and car payments. Additionally, the Diagnostic and Prevention Benefit pays an indemnity amount for one covered internal cancer screening test per covered person per calendar year.

Benefits offered by American Fidelity. Learn more at www.AmericanFidelity.com/info/cancer.

CRITICAL ILLNESS

AF™ Limited Benefit Critical Illness Insurance

If you were to experience a critical illness event, such as a heart attack or permanent damage due to a stroke, Limited Benefit Critical Illness Insurance may be able to help provide some financial protection so you can focus on your recovery.

- You choose your benefit amount: $10,000, $20,000 or $30,000.
- Pays 100% of your benefit amount for a Critical Illness such as a heart attack, permanent damage due to a stroke, major organ failure, plus more.
- Cardiac Screening benefit for covered Cardiac Screening tests, which is available without a diagnosis of a Critical Illness and does not reduce your Critical Illness benefit amount.

A full list of covered tests will be provided in your certificate.

Benefits offered by American Fidelity. Learn more at AmericanFidelity.com/info/critical-illness.

LIFE INSURANCE

AF™ Whole Life Insurance / Life; AF™ Term Life Insurance / Life; PureLife-Plus

It is impossible for life insurance to emotionally compensate for a loss, but it may help ease the financial obligations placed on your loved ones. American Fidelity's portable individual life insurance products can help.

- **Whole Life Insurance -** Provides a guaranteed level death benefit, guaranteed cash value, and guaranteed level premiums for the life of the policy, provided premiums are paid as required.
- **Term Life Insurance -** Choose from 10, 20, or 30 year term periods. Rates are guaranteed not to increase during the initial term period that you choose.
- **Pure Life Insurance (Texas Life)** - A permanent, portable product that guarantees life insurance to age 121.

Benefits offered by American Fidelity.

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.

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.

Glossary

-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.

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 under age

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-

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.

-I-

In-Network

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

Glossary

-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.

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.

Glossary

-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 / Teladoc

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 Notices
APPLIES TO MEDICARE RETIREES ONLY

Active employees may contact the District Benefits Office for questions on Medicare

MEDICARE PART D NOTICE

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Coast 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. Coast Community College District has determined that the prescription drug coverage offered by all of Coast Community College District is, 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 Coast 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 Coast 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 Coast 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 Coast 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 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 Coast 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 (800-633-4227). TTY users should call 877-486-2048.

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

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

Date:	October 1, 2022
Name of Entity/Sender:	Coast Community College District
Contact-Position/Office:	District Benefits Office
Address:	1370 Adams Avenue, Costa Mesa, CA 92626
Phone Number:	(714) 438-6804

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 deductibles and coinsurance apply. 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 Coast Community College Districts' 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 Coast Community College Districts' 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 31 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 31 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 31 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 Coast Community College Districts' 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 Coast 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 District Benefits Office.

NOTICE OF GRANDFATHERED PLAN STATUS

Coast Community College District believes the Kaiser HMO is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at District Benefits Office. You may also contact the U.S. Department of Health and Human Services at https://www.hhs.gov/

NOTICE OF CHOICE OF PROVIDERS

The HMO plans offered generally allows 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, the plans 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 the appropriate carrier depending on which plan you have enrolled in.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from any of the HMO plans 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 appropriate carrier depending on which plan you have enrolled in.

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, 2020. 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 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
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: Medicaid https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/
LOUISIANA – Medicaid
Website: http://www.medicaid.la.gov or http://www.ldh.la.gov/lahipp Phone: 1-888-342-6027 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: **Error! Hyperlink reference not valid.**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
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/oii/hipp.htm 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/ 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://dma.ncdhhs.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ 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: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: https://www.coverva.org/hipp/ Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
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 January 31, 2022, 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)
4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
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Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2023)

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 9.78% of your modified adjusted household income.

Notes

Notes

For Assistance

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

Plan Type	Provider	Phone Number	Website	Policy/Group #
District Benefits Office	Coast Community College District	(714) 438-6804 Benefits@mail.cccd.edu	Navigator.CCCD.edu/district/hr/ebr/Pages/default.aspx	N/A
Medical HMO	Blue Shield Access+	(888) 256-1915	Choose.BlueShieldCA.com/cccd.edu	W0069777
Medical HMO	Blue Shield TRIO	(855) 829-3566	Choose.BlueShieldCA.com/cccd.edu	W0069777
Medical HMO	Kaiser Permanente	(800) 464-4000	My.KP.org/cccd/	105636
Medical PPO	HealthNow (Third Party Administrator)	(844) 946-6324	MyHNAS.com Find a provider: Anthem.com/CA	U33
Prescription Drug PPO	Express Scripts	(800) 711-0917	Express-Scripts.com	COASTRX
Health Advocate	HealthNow	(866) 695-8622	HealthAdvocate.com/members	N/A
Dental	Delta Dental	(866) 499-3001	DeltaDentalIns.com	06639
Vision	VSP	(800) 877-7195	VSP.com	00246000
Life, AD&D & LTD	Voya Financial	Life, AD&D Claims: (888) 238-4840 LTD Claims: 1-888-305-0602	Voya.com Presents.Voya.com/EBRC/CCCD	0062930-8
STD	Voya and Coast Community College District	(714) 438-6804	benefits@mail.cccd.edu	N/A
EAP	Anthem Blue Cross	(800) 999-7222	AnthemEAP.com	N/A
Legal	MetLife Legal Plans	(800) 821-6400	LegalPlans.com	3080010
Voluntary Benefits	American Fidelity Assurance Company	Customer Service: (800) 365-9180 Benefits: (800) 662-1113 Flex Account: (800) 325-0654	AmericanFidelity.com	LTC: 541761 Flex: 33805

Coast Colleges

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