2022-2023

Employee Benefits Overview

EXPLORE YOUR BENEFITS

MONTEREY PENINSULA
College

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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 Notices Guide for more details.

Explore your Benefits

At Monterey Peninsula College we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

This guide is an overview and does not 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.

A list of plan contacts is included at the back of this guide.

The benefits in this summary are effective:

January 1, 2023 - June 30, 2023

LiveHealth Online: Available at No Cost!

Monterey Peninsula College offers a telehealth solution that gives you access to board-certified doctors any day of the week, while letting you skip the waiting room. **Monterey Peninsula College** has reduced the cost of your LiveHealth Online option to a $0 Copay**!** For less than an office visit, you can get diagnosed and prescribed medication by phone, computer, or mobile app. See page 8 for more details.

Who Can You Cover?

WHO IS ELIGIBLE?

In general, full-time employees working 30 or more hours per week are eligible for the benefits outlined in this overview. You can enroll the following family members in our medical, dental and vision plans.

- Your current spouse (the person who you are legally married to under state law, including a same-sex spouse) or state-registered domestic partner.
- Your children (including your Adoptive Child):
  - Under age 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.
- Any individual who is covered as an employee of Monterey Peninsula College cannot also be covered as a dependent of Monterey Peninsula College.
- Employees who work fewer than 30 hours per week, temporary employees, contract employees, or employees residing outside the United States.

ENROLLMENT PERIODS

Coverage for new full-time employees begins on the 1st of month following date of hire.

After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Notify Human Resources within 31 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment. 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 or divorce

Dependent Eligibility Details

Your dependents are eligible for coverage under your health and welfare benefits package as long as they meet the requirements specified for each plan. Reminder: Your dependents are eligible for the plan(s) based on the criteria below.

ELIGIBLE DEPENDENTS INCLUDE:

- Your current spouse or state-registered domestic partner.
  Definition of domestic partner pursuant to Family Code Section 297-297.5: A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State, and at the time of filing, all of the following requirements are met:

  (1) Both persons have a common residence.
  (2) Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
  (A) Both persons are members of the same sex.
  (B) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C section 402 (a) for old-age insurance benefits or Title XVI Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.
  (3) Both persons are capable of consenting to the domestic partnership.
  (c) “Have a common residence” means that both domestic partners share the same residence.

- Your natural children, stepchildren, domestic partner’s children, adoptive children of which the employee is the legal guardian. In addition, such children must be:
  - under age 26 for Medical and Prescription and Vision
  - under age 26 for Dental

- Your disabled children age 26 or older. Such disabled children must meet the same conditions as listed above and in addition are physically or mentally disabled on the date coverage would otherwise end because of age and continue to be disabled.

- A child for whom you are required to provide benefits by a court order and who satisfies the same conditions as listed above.

Dependent Eligibility Verification

All employees adding / removing dependents must submit documentation to verify their dependent's eligibility and / or Qualifying Life Event. The following chart is an easy guide to what documents must be submitted along with the Health Enrollment / Change form.

QUALIFYING LIFE CHANGES:

Required Documents	Enrollment Form	Marriage Certificate	State of California DP Registration	Birth Certificate /Certificate of Adoption
Employee only	•			
Employee & Spouse	•	•		
Employee & Domestic Partner	•		•	
Employee & Children	•			•
Employee, Spouse or DP & Children	•	•	•	•

You are responsible for ensuring that the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or health care services incurred during the entire ineligibility period.

For example, if your divorce or dissolution occurred in 2021, yet you did not report it until 2022, your former spouse or domestic partner will be retroactively canceled from coverage effective the first of the month following the divorce or dissolution.

On the following page, you will find a detailed list of Qualifying Life Events, which must be reported to the Human Resources Department so we can make the appropriate change to your health coverage. All Qualifying Life Event changes must be made within 30 days from the date of the event. Proper documentation is required, such as a copy of the marriage / domestic partnership certificate, birth / adoption certificate, or divorce / dissolution of domestic partnership decree.

For further clarification, please contact the Human Resources department at (831) 645-1341 or contact Lizania Sumano at lsumano@mpc.edu.

When You Can Make Changes

You may make changes to your coverage / participation if you experience a Qualifying Life Event.

QUALIFYING LIFE EVENTS INCLUDE:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, dissolution of domestic partnership, or death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status, including the start or termination of employment by you, your spouse, or your dependent child.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and fulltime employment that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment.
- Change in an individual's eligibility for Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child.
- An event that is a special enrollment event under HIPAA (the Health Insurance Portability and Accountability Act), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
  - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation;
  - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage

IMPORTANT—TWO RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

- Any changes you make must be consistent with the change in status, AND
- You must make the changes within 30 days of the date the event.

Medical

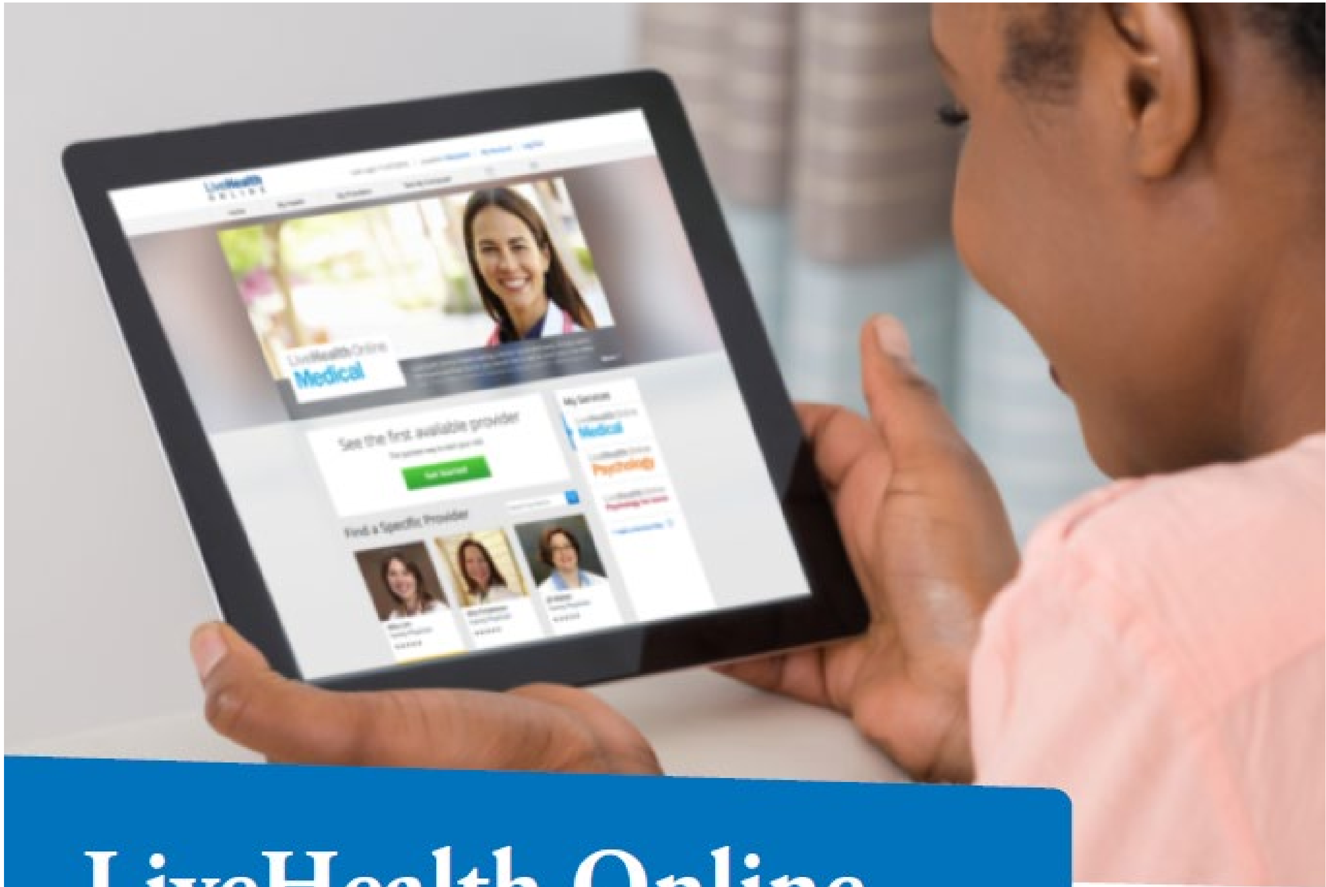
Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

PPO (Preferred Provider Organization) – The PPO plan is designed to provide choice, flexibility and value. Participants have a choice of using Preferred Providers (PPO) or going directly to any other physician (non-PPO provider) without a referral. Generally, there are annual deductibles to meet before benefits apply. You are also responsible for a certain percentage of the charges (co-insurance), and the plan pays the balance up to the agreed upon amount.

Medical PPO Plan (Anthem Network)

	In-Network	Out-Of-Network
Annual Deductible	$250 per Individual $750 per family	$500 per Individual $1,500 per family
Annual Out-of-Pocket Max	$2,500 per Individual $5,000 per family	$3,500 per Individual $7,000 per family
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$25 copay then plan pays 95%	$25 copay then plan pays 70%
Specialist	$25 copay then plan pays 95%	$25 copay then plan pays 70%
LiveHealth Online Telehealth	$0 copay	N/A
Preventive Services	No Charge	No Charge
Chiropractic Care	$25 copay then plan pays 95%	$25 copay then plan pays 70%
Acupuncture	$25 copay then plan pays 95% Max of 3 visits/week; 8 visits/diagnosis	$25 copay then plan pays 95% Max of 3 visits/week; 8 visits/diagnosis
Lab and X-ray	Plan pays 95% after deductible	Plan pays 70% after deductible
Inpatient Hospitalization	**Tier 1:** No Charge **Tier 2:** plan pays 90% after deductible	Plan pays 80% after deductible
Hospice	Plan pays 95% after deductible	Plan pays 70% after deductible
Outpatient Surgery	Plan pays 95% after deductible	Plan pays 70% after deductible
Urgent Care	$25 copay then plan pays 95%	$25 copay then plan pays 95%
Emergency Room	$100 copay/visit (copay waived if admitted) then plan pays 95%	$100 copay/visit (copay waived if admitted) then plan pays 95%

Tiered Hospital Network: Hospitals that are within the network are grouped into 1 of 3 different tiers based on the cost or efficiency of care that they provide. Tier I network hospitals have a lower co-insurance than Tier II hospitals and Tier III hospitals.



Trustmark
benefits beyond benefits

Questions?
Members: 000.000.0000
Providers: 000.000.0000
myTrustmarkBenefits.com

Member

Your Company's Logo

Employer: Your Company
Group #: XX0000
Member: 000
Member ID: 12345678910

Pharmacy Plan

Your Prescription Logo
SampleWebsite.com
Rx Help Desk: 000.000.0000

RXBIN: 000000
RXPCN: 00
RXGRP: 0000

Retail Copays: Generic $10/Preferred $35/Brand $75
Mail Order: Generic $10/Preferred $20/Brand $20

Medical Plan

Your Medical Logo

Assignment of Benefits permitted only (i) subject to the terms and conditions of the plan, and (ii) as full consideration for services/treatment rendered except for applicable copay, deductible and coinsurance.

Copays: Office Visit $35/Specialist $50
Urgent Care$75/ER $75
Deductible: $1,200 Indv/$2,500 Fam
OOP Max: $3,000 Indv/$6,000 Fam

Medical Claims

EDI: Payer ID 00000
Mail: Trustmark Health Benefits
P.O. Box 2920
Clinton, IA 52733-2920

Claims Status Inquiry: Payer ID XXXXX

Eligibility & Benefits

EDI: Payer ID XXXXX
myTrustmarkBenefits.com

This card does not guarantee eligibility or payment.

Care Management

PRE-CERTIFICATION REQUIRED
Call 000.000.0000 (members) or 800.999.0114 (providers) or visit our website at myTrustmarkBenefits.com for authorization.
You or your physician are responsible to call:
- 15 days prior to all non-urgent care elective admissions
- Prior to home healthcare services

Failure to call may result in a reduction of benefits.

NOTIFICATION REQUIRED
- Within 48 hours or the next business day of an urgent care admssion

How to get started

Rather than waiting to sign up when you're not feeling well, register today so you're ready for a visit when you need one. To sign up, visit **livehealthonline.com** or download the free LiveHealth Online app to your mobile device. Next, you:

1. Choose **Sign Up** to create your LiveHealth Online account. Then enter information like your name, email address, date of birth and create a secure password.
2. Read the *Terms of Use* and check the box to agree.
3. Choose your location in the drop-down box of states.
4. Enter your birth date and choose your gender.
5. For the question "Do you have insurance?", select **Yes.** Be sure to have your Anthem member ID card handy to complete your insurance information. If you choose **No,** you can still enter your insurance information later.
6. For **Health Plan,** in the drop-down box, select **Anthem.**
7. For **Subscriber ID,** enter your identification number, which is found on your Anthem member ID card. Select **Yes** if you are the primary subscriber or **No** if you are not the primary subscriber.
8. Insert a service key if you have one. If you don't have a service key that's OK, this is optional and not required to register.
9. Select the green **Finish** button.

Your account securely stores your personal and health information

You can be confident knowing you can easily connect with doctors when you need to consult about certain conditions, share your health history, and schedule online visits at times that fit your schedule.

Questions about how to use LiveHealth Online?

Call toll free at **1-888-LiveHealth (548-3432)** or email **help@livehealthonline.com.** If you send us an email, please include your name, email address and a phone number where we can reach you.

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. Here are the prescription drug benefits that are included with our medical plans.

	Medical PPO Plan (Anthem Network)	
	In-Network	**Out-Of-Network**
Annual Out-of-Pocket Limit	$4,100 per Individual $8,200 per family	$4,100 per Individual $8,200 per family
Pharmacy		
Generic	$5 copay	$5 copay
Preferred Brand	$20 copay	$20 copay
Non-preferred Brand	$35 copay	$35 copay
Supply Limit	30 days	30 days
Mail Order		
Generic	$10 copay	$10 copay
Preferred Brand	$40 copay	$40 copay
Non-preferred Brand	$70 copay	$70 copay
Supply Limit	90 days	90 days

Getting Care When You Need It Now

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 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°.

WHEN YOU NEED CARE NOW

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

Anthem Medical Plan Participants

- Find an urgent care center by visiting anthem.com/ca
- Use Anthem LiveHealth Online

GET A VIDEO HOUSE CALL

Anthem members can video chat with a doctor from the comfort of their own homes, without an appointment. LiveHealth Online provides 24/7 access to U.S. board-certified physicians. Physicians 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, visit livehealthonline.com.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

GOING ABROAD?

When you travel overseas, you can rely on Voya Travel Assistance. This program offers access to an international network of participating doctors and hospitals for a broad range of medical care services. For non-emergency medical care out-side the U.S, call Voya Travel Assistance collect at 800-859-2821 or 202-296-8355.The center is available 24/7 and is staffed with multilingual representatives who can help coordinate your medical care.

For more information, please see page 21 in this benefits guide.

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. Monterey Peninsula College provides you with a comprehensive coverage through Delta Dental.

	DELTA DENTAL BASE		DELTA DENTAL BUY-UP	
	In-Network	**Out-Of-Network ****	**In-Network**	**Out-Of-Network ****
Calendar Year Deductible*	None	None	None	None
Annual Plan Maximum	$1,700	$1,500 (combined with in-network)	$2,500	$2,300 (combined with in-network)
Waiting Period	None	None	None	None
Diagnostic and Preventive	plan pays 70% - 100%	plan pays 70% - 100%	plan pays 70% - 100%	plan pays 70% - 100%
Basic Services	plan pays 70% - 100%	plan pays 70% - 100%	plan pays 70% - 100%	plan pays 70% - 100%
Major Services	plan pays 50%	plan pays 50%	plan pays 50%	plan pays 50%
Orthodontic Services				
Orthodontia	plan pays 50%	plan pays 50%	plan pays 50%	plan pays 50%
Lifetime Maximum	$500	$500	$2,000	$2,000
Dependent Children	Covered	Covered	Covered	Covered
Full-time Students	Not covered	Not covered	Not covered	Not covered
Accident	plan pays 100%	plan pays 100%	plan pays 100%	plan pays 100%
Calendar Year Maximum	separate $1,000 for each enrollee	separate $1,000 for each enrollee	separate $1,000 for each enrollee	separate $1,000 for each enrollee

At an additional cost, employees are now able to purchase more coverage on a pre-tax basis. Please refer to the Rate Sheet for Employee cost.
*Deductible waived for preventive and diagnostic services.
** Patient is responsible for amount over Usual Customary and Reasonable Rate
Limitations may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.

PPO Fee: The fees that participating PPO dentists have agreed to accept as payment in full, subject to any deductibles, cost sharing and benefits maximums. Covered expense for services from non-PPO providers is based on strictly limited schedule of allowances. Members must pay charges in excess of those scheduled amounts.
Delta Dental pays for three cleanings or a dental procedure that includes a cleaning each calendar year.

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions. We offer you a vision plan through VSP.

	VSP VISION PLAN	
	In-Network	**Out-Of-Network**
Examination		
Benefit	Covered in Full	Plan pays up to $45
Frequency*	1 x every 12 months	1 x every 12 months
Materials	Covered in Full	(see schedule below)
Eyeglass Lenses		
Single Vision Lens	Covered in Full	Plan pays up to $45
Bifocal Lens **	Covered in Full	Plan pays up to $65
Trifocal Lens **	Covered in Full	Plan pays up to $85
Frequency*	1 x every 12 months	1 x every 12 months
Frames		
Benefit	$120 Allowance	Plan pays up to $47
Frequency*	1 x every 24 months	1 x every 24 months
Contacts (Elective) * **		
Benefit	$120 Allowance	Up to $105
Frequency*	1 x every 12 months	1 x every 12 months

At an additional cost, employees are now able to cover your spouse/domestic partner and/or children. Please refer to the Rate Sheet for Employee cost.

* Based on date of service.
** No-lined lenses are not a covered benefit under this plan. When requested, the lenses will be covered up to the value of the lined lenses and you will pay the additional cost.
*** When you choose contacts instead of glasses, your $120.00 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.

You may receive benefits when using non-VSP providers by submitting your claims directly to VSP. Reimbursements will be made as indicated in the Out-of-Network schedule above. Find a VSP network doctor at www.vsp.com or call 800-877-7195.

2023 Dental and Vision Plan Costs

DELTA DENTAL **Base Plan**	**Total Monthly Premium**	**MPC Monthly Contribution**	**Employee Cost (12 months)**	**Employee Cost (11 months)**
Employee Only	$45.54	$45.54	$0.00	$0.00
Employee + 1	$75.30	$75.30	$0.00	$0.00
Employee + 2 or more	$129.87	$129.87	$0.00	$0.00
Buy-up Plan				
Employee Only	$55.55	$45.54	$10.01	$10.92
Employee + 1	$91.87	$75.30	$16.57	$18.08
Employee + 2 or more	$158.43	$129.87	$28.56	$31.16

Vision	Total Monthly Premium	MPC Monthly Contribution	Employee Cost (12 months)	Employee Cost (11 months)
Employee Only	$6.08	$6.08	$0.00	$0.00
Employee + 1	$12.76	$6.08	$6.68	$7.29
Employee + 2 or more	$18.23	$6.08	$12.15	$13.26

Life 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 and pay for large expenses such as housing and education, as well as day-to-day living expenses.

Basic Life insurance provides protection for your beneficiary in the event of your death. The College currently provides Basic Life / AD&D insurance coverage at no cost to you. The chart below will outline the general benefits provided under the plan based on class and age. Please refer to your life insurance certificate of coverage for more details.

CARRIER	VOYA		THE STANDARD	
CLASS	Full-Time Classified, Confidentials, Managers, Supervisors, and Classified Administrators		Full-Time Certificated and Educational Administrators	
Employee Coverage Age Range	**Life**	**AD&D**	**Life**	**AD&D**
Under Age 25	Flat $100,000		$136,800	$136,800
Age 25-29			$120,000	$120,000
Age 30-34			$103,200	$103,200
Age 35-39			$88,200	$88,200
Age 40-44			$70,200	$70,200
Age 45-49			$52,800	$52,800
Age 50-54			$34,200	$34,200
Age 55-59			$27,600	$27,600
Age 60-64			$23,400	$23,400
Age 65-69			$14,400	$14,400
Age 70-74			$8,400	$8,400
Age 75-79			$8,400	$8,400
Age 80-84			$8,400	$8,400
Age 85 and Over			$8,400	$8,400
Dependent Coverage				
Spouse	$1,500		Dependents of Active Participants: The lesser of 50% of the Participant's Life Insurance, and b) 5,000	
Child(ren)	$1,500			
Additional Benefit Provisions				
Waiver of Premium	Included for Employee Coverage – see Certificate of Coverage for details.		Totally disabled prior to age 60	
Accelerated Death Benefit	75% of group term life		80% of in force life insurance amount	
Conversion	Included		Included	

Supplemental Life Insurance

Supplemental Life Insurance give you the opportunity to buy additional Life and AD&D insurance for yourself, spouse and child. The cost for Supplemental Life is calculated based on the age of the employee at the start of the plan's current policy year.

All Active employees under the age of 80 are now eligible. Coverage is provided by Voya. Please refer to the Voya Supplemental Enrollment form to calculate the cost.

Voluntary Life and AD&D	Voya	
Employee Life Benefit	You can elect up to $500,000 not to exceed 5 times your annual earnings in increments of $10,000. If you enroll at your initial eligibility date, you'll automatically be guaranteed up to $100,000 without completing an evidence of insurability document.	
Spouse Life Benefit	You can elect up to $250,000 for your spouse in increments of $10,000. If you enroll your spouse at your initial eligibility date, you'll automatically be guaranteed up to $25,000 without completing an evidence of insurability document.	
Dependent Child(ren) Life Benefit	You can elect up to $10,000 for your dependent children.	
Benefit Reduction Schedule	Age	% of Original Benefit
	65	65%
	75	35%
	Retirement	0%
AD&D Benefit	Same as Life	
Portability	Included	

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.

LONG-TERM DISABILITY INSURANCE

Long-Term Disability (LTD) 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.

Coverage is provided by Voya Financial.

Eligibility	
Class 1 - Certified Employees	**Certified Employees** An active F/T certified employees with 5 years of credited STRS service and working at least 20 hours per week
Class 2 - Academic Employees	**Academic Employees** An active F/T academic employee with less than 5 years of credited STRS service and working at least 20 hours per week; and all other full-time employees working 30 hours each week
Monthly Benefit Amount	Plan pays 66.67% of covered monthly earnings
Minimum Monthly Benefit	Greater of $100 or 10% of Monthly Earnings
Maximum Monthly Benefit	$3,500
Benefits Begin After:	
Accident	150 days of disability
Sickness	150 days of disability
Maximum Payment Period*	Class 1: 24 Month Duration Class 2: SSNRA

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

NEW! Employee Assistance Program

PROVIDED BY CONCERN

MPC recognizes that employees may from time-to-time experience stress, trauma or other life events that affect both their personal and work lives as well as their overall quality of life. The Concern EAP offers confidential professional assessment and referral assistance for employees and their families to help them address such challenges.

With the Concern Employee Assistance Program (EAP) you and your family will have access to the following benefits:

- **24/7 Access - Call Center or Digital platform**: Concern makes it easy to seek help by providing "human first" access to their call center or digital access to their one-stop mental health hub by phone, tablet or computer.
- **Counseling Services**: Confidential, evidence-based counseling for employees and their family members help build coping skills for real-world issues. Multiple counseling options — video, in-person, phone, live chat and text — remove access barriers and allow employees to find options that fit their preferences.
- **Work-Life Resources**: Practical guidance and solutions for life's expected/unexpected events.
- **Financial Consultation**: Certified financial advisers help with a wide range of issues such as tax questions, investments, retirement planning, getting out of debt, and saving for college.
- **Legal Consultation**: Talk with a qualified attorney on issues about divorce and family law, landlord/tenant issues, wills and trusts, immigration, identity theft, and more.
- **Parenting & Adult Care**: Concern specialists do the research for you, providing curated resources for parenting and childcare, help for aging parents or disabled family members. New parents receive a complimentary New Baby Kit.
- **Guided Mindfulness Solutions**: Fully integrated suite of live and on-demand evidence-based mindfulness solutions personalized for physical and emotional wellbeing.
- **Digital Self-Help Library**: Curated self-help resources including how-to articles, toolkits, videos, apps, assessments, and podcasts to engage, educate, and empower employees to build emotional wellbeing.

To access these benefits, contact Concern at (800) 433-4222 or visit employees.concernhealth.com and use Company Code ID "**MPC"** to register.

Flexible Spending Account

The Flexible Spending Accounts (FSA) are a great way to use pre-tax dollars to pay for expenses paid with after-tax dollars! You may enroll in either or both the Medical Spending Account or the Dependent Care Spending Account. These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible expenses that are not reimbursed by your health plans, as well as reimbursement for dependent care expenses.

Pre-tax means the dollars you allocate toward these accounts are not subject to Federal income tax and, in most cases, state and local taxes. The money you set aside may be used for qualified eligible expenses on a pre-tax basis.

MEDICAL SPENDING ACCOUNT

The maximum amount you may contribute to the Medical Spending Account for the 2023 Plan Year is $3,050. This account will reimburse you with pre-tax dollars for qualified out-of-pocket healthcare expenses not covered under your family's healthcare plans. The "Use it or Lose it" rule applies if you do not incur expenses by December 31 of the plan year.

All Medical Spending Account participants will receive a debit card that will provide you the option of having your eligible expenses paid directly from your account at the point of sale. As a debit card participant, when this happens, you do not have to pay for the expense or submit a request for reimbursement.

Medical-related expenses include out of pocket money for copays or deductibles for medical, dental and vision services. A detailed listing of all qualified expenses are available on P&A Group's website at www.padmin.com

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. You may use the Federal childcare tax credit and the Dependent Care Spending Account; however, your Federal credit will be offset by any amount deferred into dependent care plan.

Travel Assistance Provided by Voya

SECURITY WHEN YOU TRAVEL

We live in a highly connected world where frequent domestic and international travel is the norm. Voya Travel Assistance offers you enhanced security for your leisure and business trips. You and your dependent will have toll-free or collect-call access to the Voya Travel Assistance customer service center or access to the services provided on the website 24 hours a day, 365 days a year—from anywhere in the world.

COVERED SERVICES

When traveling more than 100 miles from home, Voya Travel Assistance offers you and your dependents four types of services: Pre-Trip Information, Emergency Personal Services, Medical Assistance Services, and Emergency Transportation Services.

Pre-Trip Information—these valuable services help you start your trip the right way. Voya Travel Assistance can provide you with important, up-to-date travel information including:

- Immunization requirements
- Visa & passport requirements
- Foreign exchange rates
- Embassy/consular referral
- Travel/tourist advisories
- Temperature & weather conditions
- Cultural information

Emergency Personal Services—In the event of an unexpected situation of a non-medical nature, Voya Travel Assistance offers access to several valuable services, including:

- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage or personal possessions
- Legal assistance and/or bail bond

Medical Assistance Services Include:

- Medical referrals for local physicians and dentists
- Medical case monitoring
- Prescription assistance and eyeglass replacement
- Arrangement and payment of emergency medical services (up to $10,000 with a written guarantee of reimbursement from the eligible participant).

Emergency Transportation Services—should you need medical care or assistance while traveling, Voya Travel Assistance can help. When deemed medically necessary by a Voya Travel Assistance designated physician, evacuation and transportation to the nearest adequate medical facility that can properly treat your condition will be arranged and paid for on your behalf.

Other Services Provided by VSP & Delta Dental

DELTA DENTAL: TOOTHPIC

Toothpic is an innovative app that offers virtual dental screenings for non-urgent issues from a Delta Dental PPO dentist – right from your smartphone, in under 24 hours. Delta Dental has partnered with Toothpic to provide virtual assessments from in-network dentists as a covered benefit for Plan members. Delta Dental will provide you a registration link to download the toothpic app - visit deltadental.toothpic.com to get started.

DELTA DENTAL: VIRTUAL CONSULTS

Virtual Consult connects Delta Dental members and dentists for real-time video appointments. It's totally secure and HIPAA-compliant, and it's available for free with your existing Delta Dental plan. When you have an urgent issue, even if it's after hours, Virtual Consult makes getting a dentist's advice simple. Even if you don't have a dentist that you see regularly, Virtual Consult makes urgent care, e-prescriptions and check-ins with Delta Dental dentists accessible from the comfort of your own home.

Visit deltadentalins.com/virtual-consult for more information and to learn how to download and use Virtual Consult. For best results, please use Chrome as your browser and close any VPN or firewall connections before your appointments.

DELTA DENTAL: AMPLIFON HEARING AID DISCOUNT

You now have access to discounts on hearing aids through Amplifon Hearing Health Care. Delta Dental selected Amplifon, a leader in hearing health care, to act as your personal concierge. They'll guide you through every step, from using your discounts to finding the right products and care to match your hearing needs. Call Amplifon at **888-779-1429** to be connected to a **Patient Care Advocate.**

DELTA DENTAL: QUALSIGHT LASIK

Because Delta Dental has selected QualSight to offer you access to discounts on LASIK services. Through QualSight, you can save 40-50% off the national average price of Traditional LASIK along with big savings on Custom and Custom Bladeless LASIK procedures! Call QualSight at (**855) 248-2020** for more information.

VSP TRUHEARING

VSP Vision Care members can save up to 60% on the latest brand name hearing aids. Dependents and even extended family members are eligible for exclusive savings, too! Call TruHearing at (**877) 396-7194** and mention **VSP**.

Voluntary Benefits through Aflac - OPTIONAL

In addition to the Voluntary Buy-Up Dental and Vision plans, Monterey Peninsula College is pleased to offer you a selection of voluntary benefit programs. Voluntary benefits are supplemental to your core health insurance and are optional coverages that help you customize your benefits package to your individual needs. You pay the entire cost for these plans, but you get the added convenience of paying through payroll deduction.

NOTE: The Dental and Vision options below are separate from the Dental and Vision options MPC offers.

Short-term disability Provides a source of income if the covered person becomes disabled due to a covered accident or illness.	• Guaranteed-issue options available with monthly benefit amounts up to $4,000 (subject to income requirements) and three- or six-month benefit periods.	• Monthly benefit amounts $500-$6,000 (subject to income requirements). • Portable coverage.
Hospital confinement indemnity Helps ease the financial burden of hospital stays due to a covered accident or illness by providing cash benefits.	• $500-$3,000 hospital confinement benefit. • Medical diagnostic and imaging benefit.	• Surgical, hospital and emergency room benefits. • Ambulance benefit.
Dental Provides benefits for periodic checkups and cleanings, x-rays, fillings, crowns and more.	• Guaranteed issue. • Guaranteed renewable for life. • No network. • No precertification requirements.	• No annual deductible. • Optional orthodontic rider. • Optional cosmetic benefit rider.
Vision Helps with the costs of eye exams, treatments and vision-correction materials.	• Three vision correction benefit options. • Comprehensive eye-care benefits.	• No provider network. • No coordination of benefits.
Accident Helps reduce the financial impact of a covered accident by providing cash benefits.	• Four options of coverage for injuries such as fractures, dislocations, lacerations, concussions, burns, emergency dental work, eye injuries and surgical procedures.	• Organized sporting activity benefit provides an additional benefit payout for injuries sustained while playing an organized sport.
Cancer/specified disease Helps with the costs of cancer treatment.	• One rate for all ages. • Dependent children are covered at no additional cost.	• Several plan options. • Guaranteed renewable for life.
Critical illness/specified health event Helps with the costs of treatment if you experience a covered health event, such as a heart attack, stroke or paralysis.	• Three coverage options. • First occurrence and subsequent specified health event coverage. • Continuing care benefit.	• Ambulance, transportation and lodging benefits. • Waiver of premium and continuation of coverage benefits.

Voluntary Benefits Continued

Aflac Plus Rider Can be attached to select Aflac insurance policies to provide additional benefits if diagnosed with a covered health event such as heart attack, stroke, type 1 diabetes and more.	• Guaranteed-issue and HSA-compatible options available. • Adds extra cash payouts — up to $5,000 — to existing/eligible accident, hospital and short-term disability policies.	• Includes hospitalization coverage for infectious diseases such as certain human coronaviruses (including COVID-19), pneumonia and influenza.
Lump sum critical illness Provides a lump-sum cash benefit if you're diagnosed or treated for a covered critical illness event, such as a heart attack, stroke or paralysis.	• Guaranteed issue available to all applicants for $10,000 of coverage. • Dependent children are covered at no additional cost.	• Guaranteed renewable for life. (Benefits reduce by 50% at age 75.) • HSA-compatible option available.
Lump sum cancer Provides a lump-sum cash benefit if you're diagnosed with cancer.	• Benefit options available between $10,000 - $30,000 (available in $5,000 increments) payable to policyholder upon diagnosis of internal cancer.	• Portable coverage. • Guaranteed renewable to age 75.

For Assistance

Plan Contacts

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

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	Trustmark Benefits	(800) 832-3332	www.trustmarkhb.com	L06431M001 (PPO In State) L06431M002 (PPO Out of State)
Prescription	OptumRx	(800) 356-3477	www.optum.com	610011 Use Member ID #
Dental	Delta Dental PPO	(866) 499-3001	www.deltadentalins.com	15932
Vision	VSP PPO	(800) 877-7195	www.vsp.com	104565-0193
Long Term Disability	Voya	(800) 328-4090	www.voya.com	701670
Life/AD&D	Voya (Classified, Confidential and Manager-Supervisor)	(800) 955-7736	www.voya.com	701670
Life/AD&D	The Standard (Faculty and Administrators)	(800) 628-8600	www.standard.com	503000-D
EAP	Concern	(800) 344-4222	employees.concernhealth.com	89097

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

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 FSA.

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.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

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. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred 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.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Important Plan Notices and Documents

CURRENT HEALTH PLAN NOTICES

The following pages include mandatory notices that all employers are required to provide to their employees. The contents of the notices may or may not apply to you. If you have any questions, please contact the Department of Human Resources at (831) 646-4016 or humanresources@mpc.edu.

MEDICARE PART D NOTICE

Important Notice from Monterey Peninsula College 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 Monterey Peninsula College 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. Monterey Peninsula College has determined that the prescription drug coverage offered by Monterey Peninsula College 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 Monterey Peninsula College coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under the Monterey Peninsula College Plan 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 Monterey Peninsula College 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 Monterey Peninsula College 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 Monterey Peninsula College Department of Human Resources 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 Monterey Peninsula College 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:	01/01/2023
Name of Entity:	Monterey Peninsula College
Contact Office:	Department of Human Resources
Address:	980 Fremont St., Monterey, CA 93940
Phone Number:	(831) 646-4016

“NO SUPRISES” RULES

What You Need to Know About The “No Surprises” Rules

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

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

View a sample notice and consent form (PDF).

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

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. For further details, please refer to your Summary Plan Description. If you would like more information on WHCRA benefits, call your plan administrator at (831) 646-4016 or email at humanresources@mpc.edu.

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 at (831) 646-4016 or email at humanresources@mpc.edu.

AVAILABILITY OF PRIVACY PRACTICES NOTICE

We maintain the HIPAA Notice of Privacy Practices for Monterey Peninsula College describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Monterey Peninsula College.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in the Monterey Peninsula College 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 the Monterey Peninsula College 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 the Monterey Peninsula College 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.

MICHELLE'S LAW

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

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

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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

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

Phone: 1-877-357-3268

GEORGIA – Medicaid

A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid | Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.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: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP | Phone: 1-800-694-3084 | Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/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://medicaid.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
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/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
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 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)

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

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 1/31/2023)

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this Notice carefully to make sure you understand your rights and obligations.

Notes

MONTEREY PENINSULA
College

Rev. 11/1/2022