Employee Benefits Guide

Employee Benefits Guide 2023

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NEW! Click this icon in your benefits guide to watch a video explaining the associated topic.

NEW! See page 61 for a glossary of terms.

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 54 for more details.

This is a brief summary of the benefits available under Cuesta College's plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail.

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Introduction

Our Commitment

Our greatest asset, and the key to our success, is our employees. You make the difference for the people we care for and the community we serve. That's why we've designed a benefits program to make a difference for you and your family.

Health insurance is one of the most critical benefits offered by San Luis Obispo County Community College District. A major illness or injury could be financially devastating without adequate insurance. Even the cost of treatment of minor conditions can be prohibitive. With this in mind, our benefit program is designed exclusively to meet the health care needs of you and your family.

Depending on where you live, your personal preference regarding physician choice and type of health care environment you prefer, you may choose the plan that is most suitable for you and your family members.

The benefit choices you make when you and your dependent(s) enroll will remain in place unless you experience a change in family status (e.g., marriage, divorce, or legal separation, birth, adoption, death or spousal change). If you need to change your coverage before the next enrollment period due to one of these occurrences, you must contact the Human Resources Office within 30 days of your family status change.

You can make any changes during the annual Open Enrollment period that occurs in Fall.

During this Open Enrollment period, if you are a benefit eligible employee, you may enroll or change your medical, dental and/or vision plans, as well as add any eligible dependents not previously enrolled under your coverage.

Your dependents are defined as:

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse)
- Your registered domestic partner
- Your child, a child of your spouse or domestic partner, up to age 26; ***or***
- Your legally adopted/foster child to age 26.

How to Enroll

Cuesta College is providing every employee with an opportunity to understand their employee benefits, ask questions unique to their situation, and enroll in benefits.

Online Enrollment on BenefitBridge

Self enroll at www.benefitbridge.com/sloccd

You have the ability to make changes via BenefitBridge during the 2024 Open Enrollment that will be held in the fall of 2023.

San Luis Obispo Community College District Online Benefits Enrollment is easy with BenefitBridge!

Need Help?

For all questions related to your benefits, please contact your employer's Human Resources Department. For BenefitBridge technical assistance ***only***, please contact BenefitBridge Customer Care at 800.814.1862; Mon – Fri, 8:00 a.m. – 5:00 p.m., PST or email benefitbridge@keenan.com.

Here's what you can do on BenefitBridge:

- View Current Plan Year Benefits
- Compare Plan Options
- Enroll in Benefits - For Qualifying Events and Open Enrollment
- Resource Center: Health Insurance Basics, Medicare, Glossary, Media Resources
- Add or Remove Dependents/ Beneficiaries
- Message Center
- Update My Account Info
- Available 24/7 via the Internet

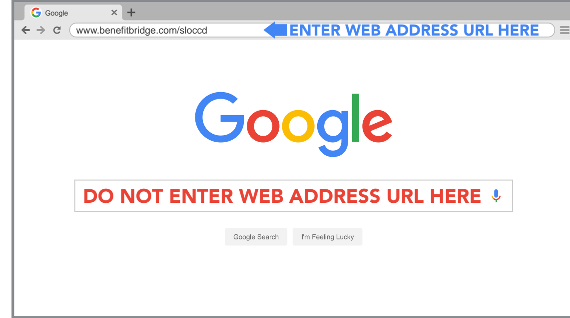
Registration and Login

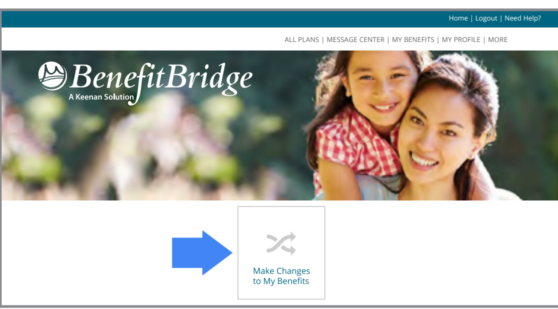
Already have login credentials?

1. Login to **BenefitBridge** at www.benefitbridge.com/sloccd
2. Forgot your Username or Password? Click on **"Forgot Username/Password?"**
3. Please add or update your email address to receive an email confirmation of your enrollment approval.

Need to create login credentials?

1. In the **address bar**, type www.benefitbridge.com/sloccd **(Not in the Google, Yahoo, Bing, etc. search engine field)**
2. Click the **Enter** key, then follow the instructions below to register:
   - **STEP 1:** Select **"Register"** to **Create an Account**
     - **You will need to create an account using your first and last names as they appear on your payroll statement.**
   - **STEP 2:** Create a **Username** and **Password**
   - **STEP 3:** Select **"Continue"** to access **BenefitBridge**





Enrolling in Benefits

Access your enrollment via the **"Make Changes to My Benefits"** button

For BenefitBridge technical assistance only, please contact BenefitBridge Customer Care at

800.814.1862

Monday – Friday, 8:00 AM - 5:00 PM, PST or email benefitbridge@keenan.com.

2023 Premium Rates and Fringe Amounts

Classified

- **Full-Time Classified Enrolled with Employee only coverage will receive up to $742.00 per month***
- **Full-Time Classified Enrolled with Employee + 1 Coverage will receive up to $790.00 per month***
- **Full-Time Classified Enrolled with Family Coverage will receive up to $913.00 per month***
- **Part-Time Classified (50%-74%) Enrolled with Employee only coverage will receive up to $371.00 per month***
- **Part-Time Classified (50%-74%) Enrolled with Employee + 1 coverage will receive up to $395.00 per month***
- **Part-Time Classified (50%-74%) Enrolled with Family coverage will receive up to $456.50 per month***

* subject to change - please visit https://www.cuesta.edu/about/depts/benefits-insurance/fringe.html for updated information

Management

- **Full-Time Management Enrolled with Employee only coverage will receive $764.00 per month***
- **Full-Time Management Enrolled with Employee + 1 coverage will receive $975.00 per month***
- **Full-Time Management Enrolled with Family coverage will receive $1,300.00 per month***
- **Part-Time Management (50%-74%) Enrolled with Employee only coverage will receive $382.00 per month***
- **Part-Time Management (50%-74%) Enrolled with Employee + 1 coverage will receive $487.50 per month***
- **Part-Time Management (50%-74%) Enrolled with Family coverage will receive $612.50 per month***

* subject to change - please visit https://www.cuesta.edu/about/depts/benefits-insurance/fringe.html for updated information

Monthly Premiums for 2023

Classified/Management/Confidential	Employee	Employee + 1	Family
***Classified Fringe**	$742.00	$790.00	$913.00
***Management/Confidential Fringe**	$764.00	$975.00	$1,300.00
Plan Year 1/1/2023 to 12/31/2023			
• Blue Shield (PPO) Plan A - $25	$1,078.00	$2,153.00	$2,797.00
• Blue Shield (PPO) Plan B - $30	$899.00	$1,796.00	$2,334.00
• Blue Shield (PPO) Plan C - $40	$903.00	$1,807.00	$2,348.00
• Blue Shield (PPO) Plan D - $50	$799.00	$1,596.00	$2,077.00
• Blue Shield (PPO) Plan E - $60	$728.00	$1,454.00	$1,890.00
• PPO Select Plan F	$707.00	$1,408.00	$1,829.00
All Staff	**Employee**	**Employee + 1**	**Family**
***Dental Plans** *(Two year commitment required)*			
• Delta Dental - Group #6736-0001 Plan A	$53.83	$95.72	$138.25
• Delta Dental - Group #6736-0003 Plan B	$60.15	$106.93	$154.50
• Delta Dental - Group #6736-01001 Plan C	$68.36	$121.57	$175.03
• Delta Dental - Group #6736-01003 Plan D	$76.38	$135.80	$196.18
Vision - Group #30071230	$11.37	$18.48	$29.30

* Fringe contribution is based on level of medical enrollment *For 50-74% positions you will receive half of the below fringe contributions

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the Plan Documents will prevail.

Opt Out Options

- All Classified employees who opt out, are entitled to receive up to the amount of $225 per month which can be spent on the District's approved plans (Dental, Vision, AFA Policies, Health Savings Account, Flexible Spending Account, AFLAC Policies, Investments, Life Insurance and Accidental Death and Dismemberment). Any unused portion will be forfeited and returned to District.
- All Management employees who elect to opt out, are entitled to receive up to the amount of $265 per month which can be spent on the District's approved plans (Dental, Vision, AFA Policies, Health Savings Account, Flexible Spending Account, AFLAC Policies, Investments, Life Insurance and Accidental Death and Dismemberment). Any unused portion will be forfeited and returned to District.

MCSIG & Rx Plan Benefits

Network: Blue Shield

MCSIG Customer Service, 800.287.1442 or 831.755.8055
Provider Search: blueshieldca.com/mcsig

	PPO $25	PPO $30	PPO $40	PPO $50	PPO $60 High Deductible Health Plan (Deductible must be met before any coverage)	PPO Select (No Out of Network Coverage)
Deductibles *(Individual / Family)*	$650/$1,300	$1,000/$2,000	$1,500 / 2x	$2,500/$5,000	$5,000 Integrated with Med/Rx Deductible, Per Person	$1,000 / 2x
Coinsurance						
• Network	20%	30%	30%	30%	30%	20%
• Out-Network	40%	50%	50%	50%	No out-of-network coverage	No out of network coverage. No coverage for Monterey County hospitals and their owned facilities
Out-of-Pocket Coinsurance Maximums						
• Single In-Network[1]	$4,000	$5,500	$6,350	$6,350	$6,350	$6,350
• Family In-Network[1]	$8,000	$11,000	$12,700	$12,700	Per person	2 x Individual
Out-Network Coinsurance Maximums[1]	$7,000/$14,000	$11,000/$22,000	$12,700 / $25,400	$12,700 / $25,400	No out-of-network coverage	No out-of-network coverage
Inpatient Hospital Coinsurance						
• In-Network*	20%	30%	30%	30%	30%	20%
• Out-Network*	40%	50%	50%	50%	No out-of-network coverage Emergency Services Only	No out-of-network coverage Emergency Services Only
Separate Hospital ER Copay *(applies if non-emergency)*	$500 ER Room	$500 ER Room	$500 ER Room	$500 ER Room	$500 ER Room	$500 ER Room

Chart is for Comparison only; Plan Evidence of Coverage Document prevails
Copayments, Coinsurance and Deductibles apply toward out-of-pocket maximum
*Subject to deductible
[1]Includes deductible

MCSIG & Rx Plan Benefits (continued)

	PPO $25	PPO $30	PPO $40	PPO $50	PPO $60 High Deductible Health Plan (Deductible must be met before any coverage)	PPO Select (No Out of Network Coverage)
Ground/Air Ambulance*	20%/20%	30%/50%	30%/50%	30%/50%	30%/30%	20%/20%
Physician Benefits	**In-Net/Out-Net**	**In-Net/Out-Net**	**In-Net/Out-Net**	**In-Net/Out-Net**	**In-Network**	**In-Network Only**
• Surgery/Anesthesia*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%
• Surgery Benefit Management Program	100% benefit when using BridgeHealth (888) 387-3909					
• Hospital Visits*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%
• Office Visits	$25 / 40%	$30 / 50%	$40 / 50%	$50 / 50%	$60	$25
• Specialist Visits	$35 / 40%	$40 / 50%	$50 / 50%	$50 / 50%	$70	$35
• Physical Exams	0% /40%	0% /50%	0% /50%	0% /50%	0%	0%
Chiropractic Care - CHPC.com *(in-network only)*	$10 copay					
Mental Health/ Substance Abuse	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%
Other Benefits	**In-Net/Out-Net**	**In-Net/Out-Net**	**In-Net/Out-Net**	**In-Net/Out-Net**	**In-Network**	**In-Network**
• Well Child Care	0% / 40%	0% / 50%	0% / 50%	0% / 50%	0%	0%
• Maternity Care*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%
• Skilled Nursing Facility* *(to 365 days/ Lifetime)*	20%	30% / 50%	30% / 50%	30% / 50%	30%	20%
• Outpatient Diagnostic X-ray and Lab Work	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%
• Acupuncture *(Any Licensed Acupuncturist)*	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year
• Durable Medical Equipment*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%

Chart is for Comparison only; Plan Evidence of Coverage Document prevails

Copayments, Coinsurance and Deductibles apply toward out-of-pocket maximum

*Subject to deductible

MCSIG & Rx Plan Benefits (continued)

	PPO $25	PPO $30	PPO $40	PPO $50	PPO $60 High Deductible Health Plan (Deductible must be met before any coverage)	PPO Select (No Out of Network Coverage)
• Outpatient Rehab/ Physical/Occupational Therapy*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	No out-of-network coverage
Prescription Drugs					Deductible must be met first	
• Out-of-Pocket Coinsurance Max						
– Single In-Network	$1,800	$1,800	$1,800	$1,800	$1,800	$1,800
– Family In-Network	$3,600	$3,600	$3,600	$3,600	$3,600	$3,600
Mail - Generic/Preferred/ Brand *(Non-Formulary)*, **90 Day Supply**	$0/$50/$90	$0/$50/$90	$0/$50/$90	$0/$50/$90	$75	$0/$50/$90
Retail - Generic/ Preferred/Brand *(Non-Formulary)*, **30 Day Supply**	$10/$25/$45	$10/$25/$45	$10/$25/$45	$10/$25/$45	$25-30 day/$50-60 day	$10/$25/$45
Retail/Maint. - Gen./Pref./ Brand *(Non-Formulary)*, **30 Day Supply**	$15/$40/$60	$15/$40/$60	$15/$40/$60	$15/$40/$60	$15/$40/$60	$15/$40/$60
Specialty, 30 Day Supply	$25/$75/$125	$25/$75/$125	$25/$75/$125	$25/$75/$125	$225	$25/$75/$125

Chart is for Comparison only; Plan Evidence of Coverage Document prevails

Copayments, Coinsurance and Deductibles apply toward out-of-pocket maximum

*Subject to deductible

Click here to watch a video on Preferred Provider Organizations (PPO).

Municipalities, Colleges, Schools Insurance Group (MCSIG)
Pharmacy Plan Summary

Express Scripts is the company chosen by MCSIG to administer your prescription benefit plan. Your Express Scripts pharmacy plan is designed to help you save money and get the best service for you, and your family's medication needs.
Express Scripts offers:

- *a 24-hour, 365 days per year Customer Service Call Center; **(866) 321-9650**,*
- *a national network of over 70,000 contracted pharmacy stores,*
- *Classic Option only - Home Delivery of your medications through the Express Scripts Mail Service Pharmacy,*
- *Your personalized information web site; www.express-scripts.com or mobile app.*

Pharmacy Copayments

PPO Select, 25, 30, 40, 50 Retail – 60 Day Supply	PPO 60 Retail – 60 Day Supply
Generic - $10.00	Generic - $25.00 30 day, $50 60 day
Preferred Brand - $25.00	Preferred Brand - $25.00 30 day, $50 60 day
Non-Preferred Brand - $45.00	Non-Preferred Brand - $25.00 30 day, $50 60 day
Mail Service- 90 Day Supply	**Mail Service – 90 Day Supply**
Generic - $0	Generic - $75
Preferred Brand - $50.00	Preferred Brand - $75.00
Non-Preferred Brand - $90.00	Non-Preferred Brand - $75..00

*** PPO Select, 25,30,40 and 50 Specialty copays are: Generic $25, Formulary Brand $75 and Non Formulary Brand $125, for PPO 60 they are $225***

****The Affordable Care Act (ACA)** ensures that everyone has access to certain categories of preventive care products, free of charge, to those who qualify. Examples include Aspirin, Contraceptives, Fluoride Supplements, Smoking Cessation, Fluoride, Folic Acid, Bowel Prep, and Vitamin D.*

*** Select Home Delivery – if member chooses to fill maintenance meds at retail after 2nd fill copays will increase to: Generic $15, Formulary Brand $40 and Non Formulary Brand $60.***

Select Home Delivery Program–Incentive Choice; This Home Delivery program will encourage you to consider where you purchase your maintenance medications. Your first two (2) fills at any retail pharmacy will be offered at the copay price offered above. After your second fill, your copay may increase. The program is designed to remind you of the benefits and potential savings through the Express Home Delivery pharmacy. You can call Express Scripts' **Member Choice Center at 877/603-1032** to review your options with a specialist; You can either transfer your prescriptions to Home Delivery, or continue filling your prescriptions at retail.

To learn more, you can go to www.StartHomeDelivery.com or contact Express Scripts *Customer Service Call Center* at the number above.

- **Safety:** Pharmacists check every prescription for accuracy and potential drug interactions.
- **Service:** Talk confidentially to a pharmacist 24 hours a day, every day.
- **Convenience:** Order refills easily by mail, phone or online.

Using A Participating Retail Pharmacy; Express Scripts has secured a large network of pharmacies contracted to accept discounted pricing. You can locate a network pharmacy by checking www.express-scripts.com, or calling customer service. Using a network store translates to plan savings for you and Marshall Medical Center. Present your Express Scripts ID card to the pharmacist. The pharmacy will submit your prescription claim to Express Scripts for processing. Your applicable copayment will be shared with the pharmacy. Your pharmacist will collect your copayment when you pick up your prescription. *If you use a **Non-Participating pharmacy**, you will need to pay the full cost of your medication and mail a copy of your receipt with a manual claim form to Express Scripts.* Your reimbursement will be based on the allowed amount, not what you paid at the store.

Accredo Exclusive Specialty Program; If you use a specialty medication to treat a condition such as cancer, multiple sclerosis, or rheumatoid arthritis, you will need to begin using the Accredo specialty pharmacy after your 1st fill at a retail pharmacy. On the 2nd attempt to fill at a retail pharmacy your copay will be 100%. To avoid paying high cost, please call 1-800-803-2523 to get a new prescription through Accredo. Accredo offers a concierge service for Express Scripts patients including direct outreach to your doctor to collect your prescription, and phone access to nurses and pharmacists.

Step Therapy; For some of the more common conditions there are many drug choices available. The Express Scripts Step Therapy Program encourages cost-effective choices through a letter-based Prior Authorization process. First-line drugs are automatically allowed and include generic or preferred brand-name. Second-line products would include higher cost products, or non-preferred brand name medicine. If you attempt to purchase a second-line drug first, the purchase will be denied with a message to try a first-line alternative. Express Scripts will immediately send you a letter that outlines choices you can discuss with your doctor. *(In order to start a second line drug first, your physician would need to establish a medical necessity for that product and secure Prior Authorization through Express Scripts.)*

Prior Authorization; Prior Authorization is a program that helps you get the prescription drugs you need *with safety, savings and — most importantly — your good health in mind.* It helps you get the most from your healthcare dollars with *prescription drugs that work well for you and that are covered by your pharmacy benefit*. It also helps control the rising cost of prescription drugs for everyone in your plan. The program monitors certain prescription drugs to ensure that you are getting the appropriate drugs for your disease state. It works much like healthcare plans that approve certain medical procedures before they're done, to make sure you're getting tests you need: If you're prescribed a certain medication, that drug may need a "prior authorization." *It makes sure you're getting a cost-effective drug that works for you.* For instance, prior authorization ensures that covered drugs are used for treating medical problems rather than for other purposes.

Prior authorization will be required for certain medications. If you have questions on a particular drug, please contact Customer Service or visit express-scripts.com to perform a coverage check. Please have your doctor call Express Scripts at 1-800-753-2851 to go through a clinical review of your medication, if it is subject to prior authorization.

Most prescription medications are covered by your plan. Excluded products are noted below.

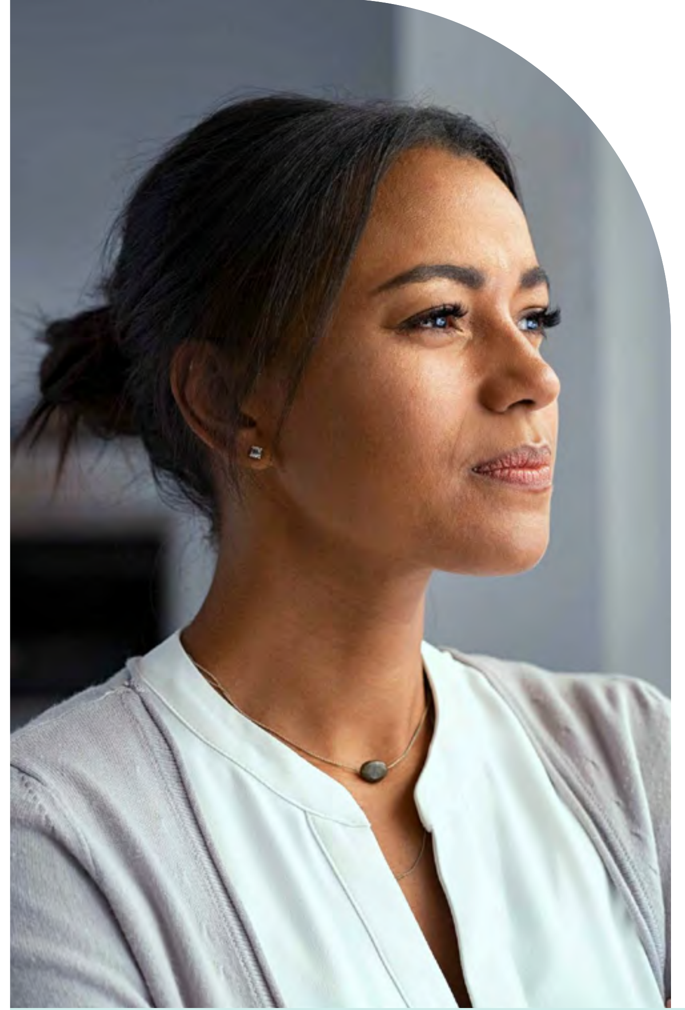
- *All over-the-counter products & drugs, and OTC equivalents*
- *Depigmentation and Photo-Aged Skin products;- Renova, Avage, Vaniqa,*
- *Injectable cosmetic drugs; Botox, Myobloc*
- *Homeopathic products*
- *Yohimbine*
- Alpha-1-Proteinase Inhibitor
- Durable medical equipment (DME)
- Infliximab (Std) Remicade
- Rituximab/Rituxan
- *Abortifacients, IUDs, Contraceptive Implants, Devices and Injectables (Depo-provera)*
- *Fertility Agents*
- *Hair growth products, agents to treat hair loss*
- *Diagnostics testing products/solutions and Rx imaging products*
- *Medications that have been re-packaged, or meds prepared for unit doses*
- Alefacept/Amevive
- Continuous Glucose monitors & kits

Prescription Services On-Line

Express Scripts offers a world class patient interactive web site. If you have a computer at home, or at work, you are welcome to log on, register and view the information available to you. www.express-scripts.com. This web-site allows you to;

- locate pharmacies,
- pay your Mail Service co-insurance balance on-line,
- order Mail Service refills, check the status of your order, and make updates to your account,
- send email questions to a pharmacist on-line,
- review your choices and cost before going to the store, use the "***My Rx Choices***" tool to review your choices and coverage.

Express Scripts Home Delivery Pharmacy PO Box 66567 St Louis, Mo	Express Scripts Customer Service *(866) 321-9650* Open 24 hours, 365 days a year	Express Scripts Website www.express-scripts.com



Need Surgery?

You deserve the best.

With Transcarent Surgery Care, **you pay $0**. If you are enrolled in a high deductible plan, you pay $0 after your deductible has been met.

Our promise to you:

EXPERIENCE

Leave the details to us. Our Care Coordinators are committed to giving you a better health and care experience. It's the personal support and guidance everyone deserves.

RESULTS

You deserve to be treated like a VIP. We're committed to providing you the best possible outcome, and it starts with access to select providers who have been verified to deliver the best results specific to your needs.

AFFORDABILITY

You don't have to avoid surgery because of cost. MCSIG and Transcarent are committed to providing you optimal care at a lower out-of-pocket cost to you.

It was a wonderful experience for me. My care coordinator gave me several options. I chose a provider, and she handled everything else. It was so easy and seamless.

— **IANTHA**
Transcarent Member

Questions? Call Transcarent Surgery Care at **(855) 586-2744** or visit **experience.transcarent.com/mcsig**

MCSIG Surgery Care Program Summary

Care Coordination	Your Care Coordinator manages the entire surgery process so you don't have to — from answering your questions, handling paperwork, scheduling appointments, and all the logistics of your surgery, we've got you covered.
Coverage	**PPO Plan** *(non-HSA Plans)*: Surgery costs are covered at 100%. There is no deductible or coinsurance when you choose a Transcarent provider. **High Deductible Plan** *(HSA Plans)*: Surgery costs are covered at 100% after you meet your deductible. There is no coinsurance when you choose a Transcarent provider. Transcarent coordinates with your health plan to verify your remaining deductible amount prior to surgery. A credit card is required to pay the deductible balance.
Surgery Expenses	Surgery costs paid through Transcarent include: • Preoperative surgeon appointment • Surgery (all facility, anesthesia, surgical staff, and surgeon charges) • In-patient services, if a hospital stay is required • Postoperative surgeon appointment Medical expenses that occur before the preoperative surgeon appointment and after your postoperative appointment are covered by your health plan and subject to plan guidelines, deductible, and coinsurance.
Travel Expenses	If a local surgeon isn't an option and travel over 100 miles (one way) from the patient's primary residence is required, Transcarent pays travel expenses for the patient and a companion, including: • Airfare (coach unless first class is medically necessary) • Lodging (one double occupancy room) • Meals and incidentals allowance: – *$50 per day for the patient when not admitted (days 1-14)* – *$50 per day for a companion (days 1-14)* – *$125 per week per person after 14 days (days 15+)* Airfare and lodging must be arranged by your Transcarent Care Coordinator for coverage. A travel companion is required and must be at least 18 years of age. You'll receive a pre-paid debit card for meals and incidentals a few days before your surgery.
Surgical Procedures	Bariatric, Cardiac, General, Neurological, Orthopedic, Spine, Vascular, and Women's Health. Emergency, pediatric (under age 13), cancer, cosmetic, dental, diagnostic, vision and transplant procedures are not available through Transcarent Surgery Care.
Shared Savings Rebate	When you choose a Transcarent provider, you may receive a shared savings rebate between $500 and $4,500. MCSIG saves money with Transcarent's bundled surgery rates and shares the savings with you. The shared savings rebate is determined by the overall plan savings and paid to you by MCSIG after surgery.
Virtual Physical Therapy	Relieve pain or rehabilitate from the comfort of your home. Whether it's easing pre-surgery back, joint, or muscle pain or post-surgery rehab, a licensed physical therapist will design your program, mail you all the tools you'll need (including a pre-programmed tablet and sensor straps) to monitor your progress, and make adjustments as necessary. Ask your surgeon if virtual physical therapy is recommended for your care plan.

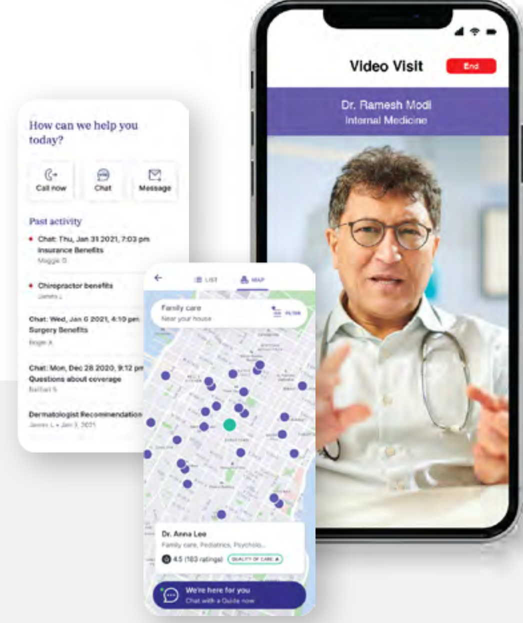
transcarent

Questions? Call Transcarent Surgery Care at **(855) 586-2744** or visit **experience.transcarent.com/mcsig**

Transcarent Health and Care Experience
NOW INCLUDED IN YOUR MCSIG BENEFITS
Health and Care
the way it should be
Transcarent is your single point of access for all your health care benefits.
Every day, any time of day, you have information, support and high-quality care at your fingertips—all at no cost to you.
Earn one Healthy Reward$ point by activating Transcarent!
My Benefits
Included with Transcarent
See all
Surgery Benefits
Chat with a doctor now
Browse benefits
Medical
Vision
Dental
Pharmacy
Transcarent
ACTIVATE NOW
ONLINE:
experience.transcarent.ai/MCSIG
DOWNLOAD THE MOBILE APP:
Search for "Transcarent" in the app store
OPEN & SCAN

Transcarent Health and Care Experience

Your Health, Your Care at your fingertips



Forget about opening multiple tabs, rifling through your filing cabinet and trying to track down information—**Transcarent is your single point of access when it comes to health care.**

SurgeryCare with BridgeHealth

When you need surgery, we help you get the best care for your procedure—best of all, MCSIG makes sure you pay little to nothing. Our Care Coordinators guide you through the surgery process so you can focus on your health and recovery.

24/7 Virtual Care *Telehealth*

We make connecting with a doctor as easy as texting a friend. Skip the wait and talk to a doctor when it works for you—in under 60 seconds. No pre-registration or appointment needed.

Health Guides

When it comes to your health, sometimes you just want to talk to a person—the same person so you don't have to tell your story multiple times. Our Health Guides are here 24/7 to help you by phone, or log into chat.

Virtual Physical Care

Are you suffering from back, joint or muscle pain? Our virtual physical care program is an effective alternative to in-person physical therapy that you do from the comfort of home. A physical therapist designs a program just for you and is there to chat any time.

Decision Support & Second Opinion

Make medical decisions with confidence and ensure you receive high-quality care. We can connect you with a team of expert doctors and nurses to help you understand medical conditions, learn about available treatment options and get a virtual second opinion.

My Benefits *via the Transcarent App*

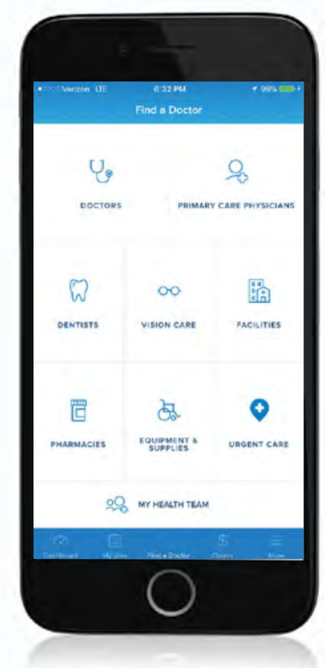
Access all your health and care benefits offered by MCSIG in one convenient place through the Transcarent app.

Transcarent **Activate Online:** experience.transcarent.ai/MCSIG **Talk to a Health Guide 24/7:** (855) 586-2744

MCSIG & Rx Plan Benefits - 24/7 Access

Manage your health care anytime, anywhere from your phone, tablet, or computer

Get 24/7 access to your Blue Shield health plan information through our mobile app and website.

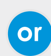


Download on the App Store

GET IT ON Google play

It's easy to get started:

From your phone, download the Blue Shield of California mobile app on the App Store℠ or Google Play™ and click register.



From your computer, register for your online account at blueshieldca.com/register.

Once you register, you'll be able to:

- Find a doctor or urgent care center near you
- View or print your Blue Shield member ID card
- Check your deductible and copayment/coinsurance year-to-date totals
- View your claims
- Review your benefits information

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blueshieldca.com

MCSIG & Rx Plan Benefits - Express Scripts

Your health plan recommends home delivery pharmacy services from Express Scripts.[1]

» Home delivery is easy, safe and convenient

Get up to a 90-day supply of your medicine for a single home delivery copayment by using home delivery for the prescriptions you take regularly. This valuable part of your prescription benefit includes free standard shipping.

Get started

Let Us Help You

For transfers from a retail pharmacy, sign in at **Express-Scripts.com** or

Speak to a prescription benefits specialist
800.698.3757
(7:30 a.m. – 5 p.m., Central, Monday-Friday)

OR

Do It Yourself

1. Complete a home delivery order form[2]
2. Get a 90-day prescription from your doctor plus refills for up to one year (if applicable)
3. Include your home delivery copayment (acceptable forms include credit/debit card, check or money order)[3]
4. Mail your form and prescription to Express Scripts at the address on the form

You can also have your doctor ePrescribe or fax your prescription.

Your medication will arrive by mail within 8 days of receipt of your initial prescription.

Get refills

Choose Worry-Free Fills® and we'll automatically refill for you.

Order a refill online or by phone 24/7 when you have 30 days (or one month) of medication remaining so you don't run out.

Join the millions of Americans who already enjoy the safety and convenience of home delivery pharmacy services – from Express Scripts – to your door.

If you have any questions about home delivery pharmacy services from Express Scripts or your prescription benefit, please call the number on your member ID card.

[1] Includes services provided by the Medco Pharmacy® and the Express Scripts Pharmacy℠.
[2] Visit Express-Scripts.com and click on "Forms" on the left-hand side of your computer screen or call the phone number on your member ID card to request a home delivery order form.
[3] Contact Express Scripts at the phone number on your member ID card if you don't know your home delivery copayment.

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ACUPUNCTURE

Benefits include

$2,000, per person

Per Year Coverage

All MCSIG PPO Medical Plans

Use the Blue Shield Network for Greater Savings

Find a participating Acupuncturist at:

blueshieldca.com/mcsig

MCSIG Customer Service

831-755-8055

800-287-1442

MCSIG & Rx Plan Benefits - Teladoc

Blue Shield of California offers Teladoc:
Access to licensed doctors 24/7 by phone or video

Get care when and where you need it through your Blue Shield health plan. As a Blue Shield member, you have access to Teladoc's national network of U.S. board-certified physicians, licensed in California. Whenever you need care, Teladoc® doctors are available 24/7 by phone or video.

Use Teladoc

- If you're considering the ER or urgent care center for a non-emergency
- When on vacation, a business trip, or away from home
- For short-term prescription refills

Get the care you need

Teladoc doctors can treat many medical conditions including:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Respiratory infection
- Sinus problems
- And more

Meet the doctors

All Teladoc doctors:

- Are practicing primary care physicians, pediatricians, and family physicians
- Have an average of 20 years of experience
- Are board certified and licensed
- Are credentialed every three years

Get started with Teladoc

❶ Set up account

Visit **teladoc.com**, complete the required information, and click on *Set up account*. You can also call Teladoc at **1-800-Teladoc** (835-2362) for help.

❷ Provide medical history

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

Web: Log in to **teladoc.com** and click *Update medical history*.

Mobile: Visit **Teladoc.com/mobile** to download the app. Log in, go to the menu icon on the top left, and click *Medical Info.*

Phone: Teladoc can help you complete your medical history over the phone. Call **1-800-Teladoc** (835-2362).

❸ Request a consult

Once your account is set up, request a consult anytime you need care.

Talk to a doctor anytime for a copay of $0

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Teladoc Dermatology

Welcome to an easier way to get healthy skin

Having problems with your skin? Teladoc Dermatology can help. It's a fast, convenient benefit available to Blue Shield of California members for a $0 copay.

Instead of waiting weeks to get an appointment, you can get a diagnosis and treatment plan in just two business days. Teladoc's board-certified dermatologists treat a wide variety of skin conditions by web or app, including psoriasis, acne, moles, rosacea, and more.

The process is simple and easy

Request a Dermatology consult on **teladoc.com**, or with the Teladoc app, and follow these three steps:

1. Answer a few questions about your skin.
2. Upload up to three photos for the doctor to view.
3. Receive a diagnosis, treatment plan, and have any needed prescriptions sent to your pharmacy.

Teladoc.com | **Teladoc.com/mobile**

Blue Shield of California is an independent member of the Blue Shield Association A52142 (1/20)

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Teladoc physicians reserve the right to deny care for potential misuse of services. 10E-220_249109584_08022018

care you can
count on.

TELADOC.

Get support from a mental health professional no matter where you are with Teladoc's behavioral health service

Taking care of your mental health is as important as exercising and eating right. Now, getting the help you need is easier than ever. As a Blue Shield of California member, you can speak to a licensed mental health professional by phone or video with Teladoc's behavioral health service.*

This service, which is available to adults age 18 and older, can help you manage addiction, depression, stress or anxiety, domestic abuse, grief, and more. You can choose to see a licensed psychiatrist, psychologist, social worker, counselor, or therapist and establish an ongoing relationship.

With Teladoc, you can also speak to a medical doctor 24/7 by phone or video for non-emergency conditions such as the flu, allergies, and more.

Why use Teladoc's behavioral health service?

1. Meet with a licensed mental health professional by phone or video when it's easy and convenient for you.
2. Connect for a completely confidential session.
3. Make an appointment seven days a week, 7 a.m. to 9 p.m. local time.
4. Have Teladoc psychiatrists prescribe drugs when medically necessary.
5. Get quick access to a licensed psychiatrist, psychologist, counselor, or therapist who meets your needs.

Talk to a doctor anytime for a $0 copay†

Psychologist, therapist, counselor, or licensed clinical social worker.........$0

Psychiatrist initial visit............................$0

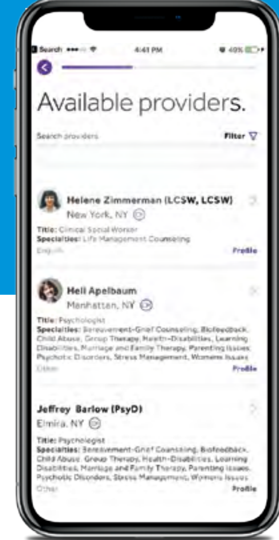
Recurring visits.......................................$0

Please note: This service does not include a crisis hotline. Help is available if you or someone you know is in crisis. Call the National Suicide Prevention Lifeline at **1-800-273-TALK (8255)**. You'll need to schedule an appointment to speak with a licensed therapist.

* To see if you are eligible to use this service, see your *Evidence of Coverage* or *Certificate of Insurance* for a complete description of benefit details, exclusions, limitations, and conditions of coverage.

† Please see your *Evidence of Coverage* or *Certificate of Insurance* for a detailed description of coverage benefits.

> "As a working mom with two small children, finding 'me time' is almost impossible. So having easy access to an amazing psychologist through Teladoc has been an invaluable benefit."
>
> **– Susan B.**
> Current patient



How to request an appointment

Scheduling a phone or video appointment with a therapist is easy and convenient. You can make an appointment seven days a week from 7 a.m. to 9 p.m. local time. Teladoc confirms appointments within 72 hours.

How to schedule an appointment

1. Register at **blueshieldca.com/teladoc**. If you already have a Teladoc account, log in at **Teladoc.com/bsc**, or visit **Teladoc.com/mobile** to download the Teladoc app.
2. Log in to your account to request an appointment (appointments can only be scheduled online).
3. Request a behaviorial health visit and complete a short intake form.
4. Select your provider, complete the emotional health questionnaire, and choose three appointment times that are best for you.
5. Request your first appointment.

Please schedule your appointment online or via the Teladoc app.

Although call center representatives cannot schedule appointments for you, they can answer your questions about this service and the types of therapists available.

Confidential therapy when you need support

blueshieldca.com/teladoc | **Teladoc.com/bsc** | **Teladoc.com/mobile**

Blue Shield of California is an independent member of the Blue Shield Association A51473-ZERO (1/20)

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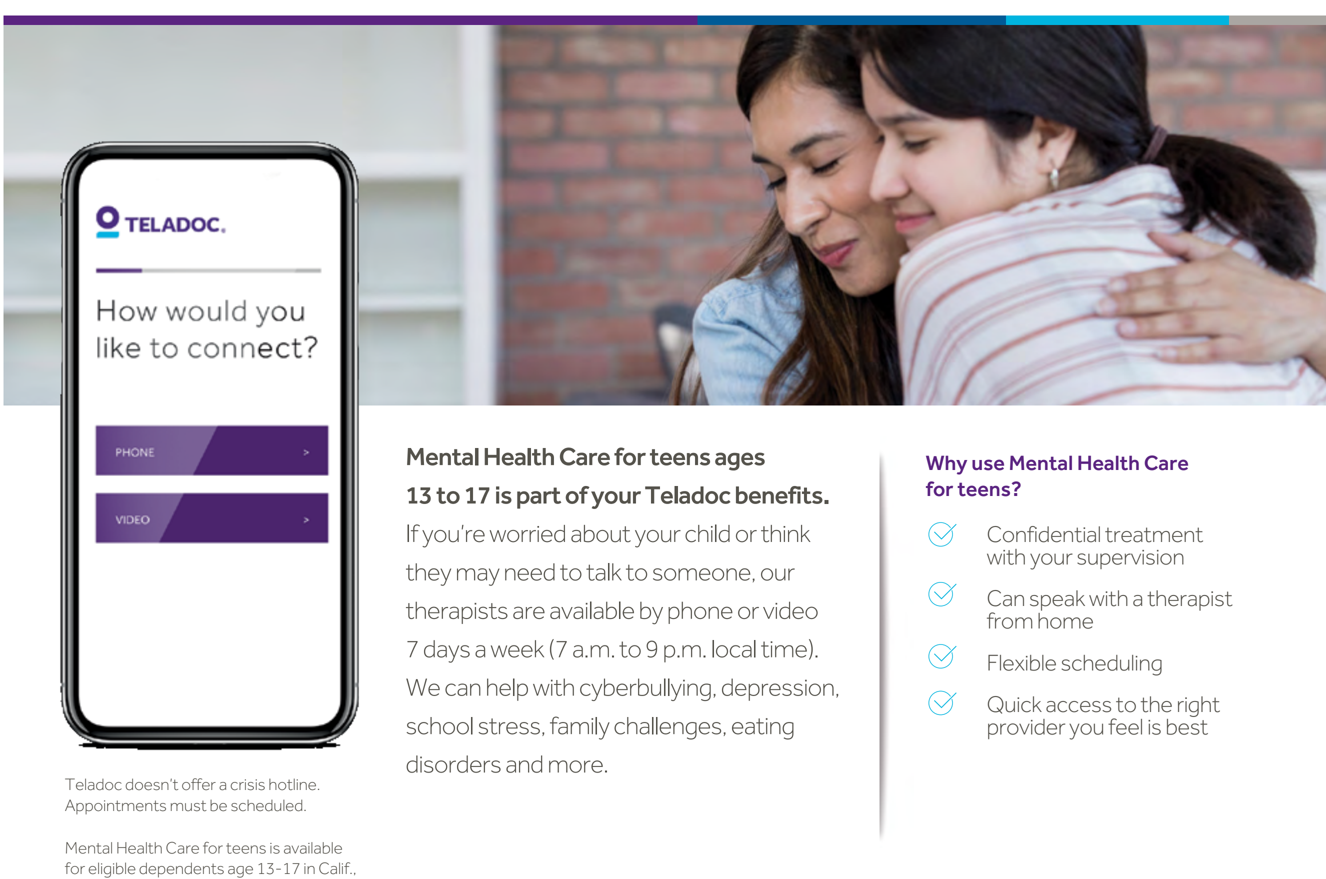
Whatever your teen is facing, we can help.

Schedule a therapist visit by phone or video.



Mental Health Care for teens ages 13 to 17 is part of your Teladoc benefits.

If you're worried about your child or think they may need to talk to someone, our therapists are available by phone or video 7 days a week (7 a.m. to 9 p.m. local time). We can help with cyberbullying, depression, school stress, family challenges, eating disorders and more.

Why use Mental Health Care for teens?

- Confidential treatment with your supervision
- Can speak with a therapist from home
- Flexible scheduling
- Quick access to the right provider you feel is best

Teladoc doesn't offer a crisis hotline. Appointments must be scheduled.

Mental Health Care for teens is available for eligible dependents age 13-17 in Calif., Fla., Ga., Pa. or Texas.

Supervised therapy for the teen in your life

Call 1-800-TELADOC (835-2362) | Visit Teladoc.com

Download the app

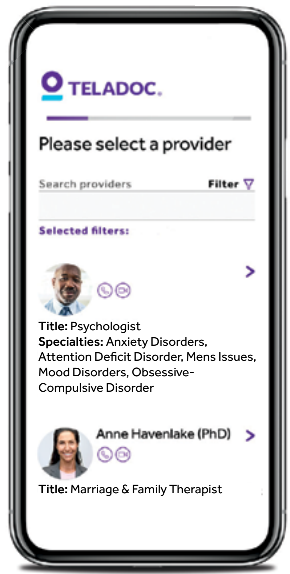
Mental Health for teens
How to schedule a visit

1. Set up a Teladoc account by web or app or log in to your account if you're already registered, then add your teen as a dependent.

2. Download and print the consent form and the intake form. The completed forms must be uploaded before a mental health visit can be scheduled for the teen.

3. Select the therapist of your choosing for your teen.

4. Request a time for the appointment and receive confirmation.



Important reminders for parents/guardians:

- One parent/guardian must be present at the beginning and end of each visit.
- Both parents must print, sign and upload the consent form by web or app..
- One parent will need to complete an intake form/questionnaire for the teen. (It takes about 10 minutes to complete).

We're here to help. Schedule today.

Call 1-800-TELADOC (835-2362) | Visit Teladoc.com

Download the app

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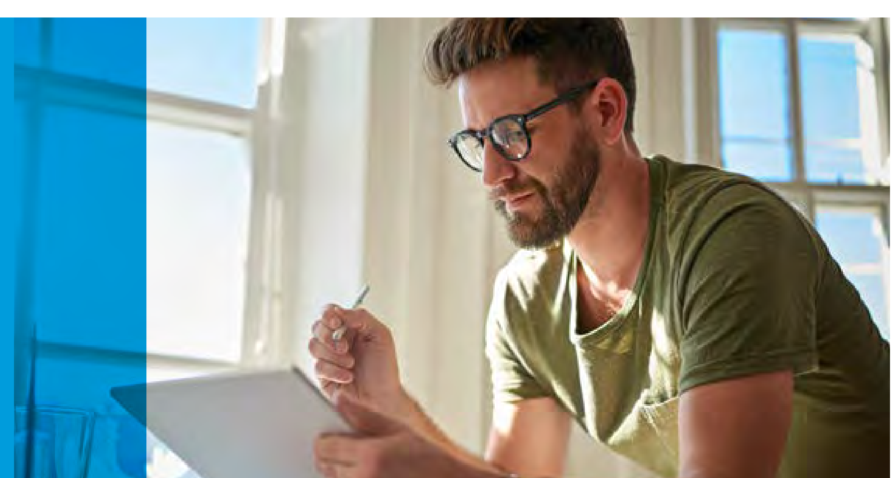
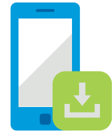
Employee Assistance Program

Professional support and guidance for everyday life

Life doesn't always go as planned. And while you can't always avoid the twists and turns, you can get help to keep moving forward.

We can help you and your family, those living at home, get professional support and guidance to make life a little easier. Our Employee Assistance Program (EAP) is available to you in addition to the benefits provided with your MetLife insurance coverage. This program provides you with easy-to-use services to help with the everyday challenges of life — at no additional cost to you.





Help is always at your fingertips.

Our mobile app makes it easy for you to access and personalize educational content important to you.

Search "LifeWorks" on iTunes App Store or Google Play. Log in with the user name: **metlifeeap** and password: **eap**

Expert advice for work, life, and your well-being

The program's experienced counselors provided through LifeWorks — one of the nation's premier providers of Employee Assistance Program services — can talk to you about anything going on in your life, including:

- **Family:** Going through a divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Job relocation, building relationships with co-workers and managers, navigating through reorganization
- **Money:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- **Legal Services:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning
- **Identity Theft Recovery:** ID theft prevention tips and help from a financial counselor if you are victimized
- **Health:** Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- **Everyday Life:** Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet

Convenient and confidential help when you want it, how you want it

Your program includes up to 5 in person, phone or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year. You can call **1-888-319-7819** to speak with a counselor or schedule an appointment, 24/7/365.

When you call, just select "Employee Assistance Program" when prompted. You'll immediately be connected to a counselor.

If you're simply looking for information, the program offers easy to use educational tools and resources, online and through a mobile app. There is a chat feature so you can talk with a consultant to guide you to the information you are looking for or help you schedule an appointment with a counselor.

Log on to metlifeeap.lifeworks.com, user name: metlifeeap and password: eap

Made available by:

Navigating life together

Answers to important questions

Are Employee Assistance Program services confidential?
Yes. Any personal information provided to LifeWorks stays completely confidential.*

How do I get help?
Getting professional help is just a phone call away. Simply call 1-888-319-7819 to speak with a counselor or to schedule an in person, phone or video conference appointment. These services are available 24 hours a day, 7 days a week.

When is the right time to call?
That's up to you. Counselors are here whenever you need them —whether you simply need to talk or want guidance on something you are going through.

Is my Employee Assistance Program included with my MetLife coverage?
Yes. There is no cost to you because your employer pays for the services provided within our program. While we offer a broad range of services, there may be some assistance that's not included. You can still work with counselors for these services by arranging to pay for them directly.

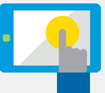
Does the program have any limitations?
While we offer a broad range of services, we may not cover all services you may need. Your Employee Assistance Program does not provide:

- Inpatient or outpatient treatment for any medically treated illness
- Prescription drugs
- Treatment or services for intellectual disability or autism
- Counseling services beyond the number of sessions covered or requiring longer term intervention
- Services by counselors who are not LifeWorks providers
- Counseling required by law or a court, or paid for by Workers' Compensation

When you need some support, we're here to help.

Phone
1-888-319-7819

Web
metlifeeap.lifeworks.com
user name: metlifeeap
and password: eap



Mobile App
user name: metlifeeap
and password: eap

*MetLife and LifeWorks abide by federal and state regulations regarding duty to warn of harm to self or others. In these instances, the consultant may have a duty to intervene and report a situation to the appropriate authority.

Some restrictions may apply to all of the above-mentioned services. Please contact your employer or MetLife for details.

Made available by:

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
OPT2/3 L0219512255[exp0220][All States][DC,GU,MP,PR,VI] © 2019 MetLife Services and Solutions, LLC

MCSIG & Rx Plan Benefits - Brightline

Get virtual behavioral health support for **your family**

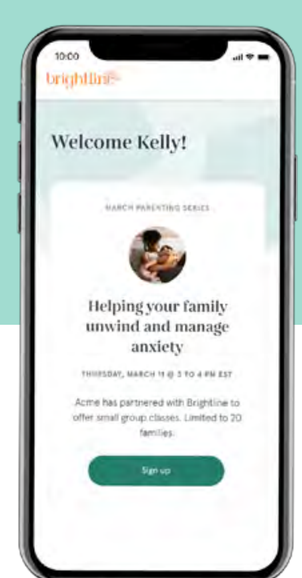
Brightline's services — what's covered:

START HERE

Connect+

On-the-go access to personalized content, group classes, interactive exercises, and chat with coaches for tips and guidance

Available nationwide



GET SUPPORT WHEN YOU NEED IT

Coaching

Programs to help tackle everyday common challenges with expert behavioral health coaches in as few as four sessions

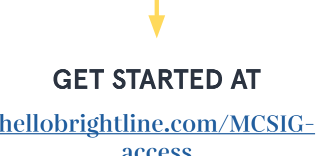
Available nationwide

Care

Personalized behavior therapy, speech therapy, and medication evaluation & support from licensed Brightline clinicians

Available in select states and coming nationwide soon

Brightline's services are covered benefits via Blue Shield of California and your employer, for children covered as dependents on your benefits. We'll check your eligibility when you sign up. Deductibles and copays apply.



GET STARTED AT

hellobrightline.com/MCSIG-access

Questions? Get in touch with Brightline Member Support

888-224-7332 **care@hellobrightline.com**

How to get started?

1. Easily and quickly sign up at hellobrightline.com/MCSIG-access
2. Create an account and access Brightline Connect+
3. Answer a few questions so we can get you the right care
4. Schedule your first appointment with no wait list

Why go with Brightline?

NO MORE QUESTION MARKS

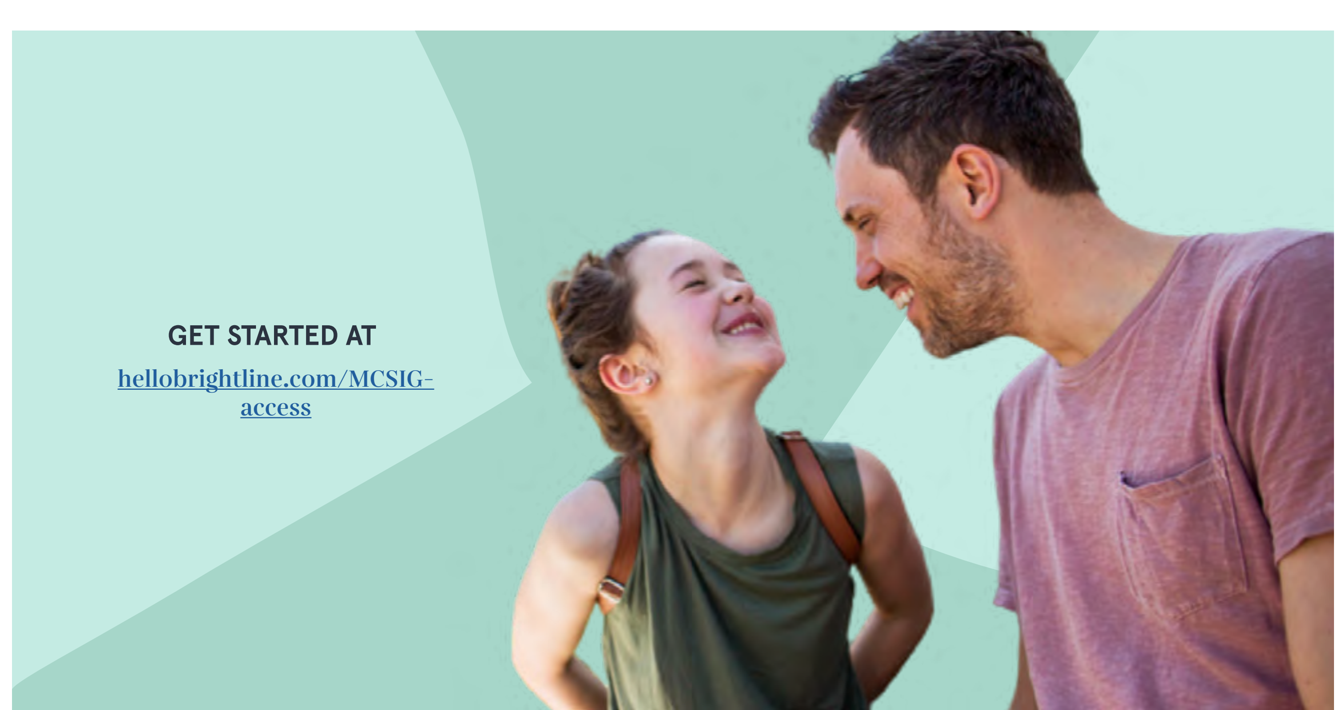
We get you answers and support at every step, from check-ins with your child's therapist to regular progress updates.

THE RIGHT CARE AT THE RIGHT TIME

Our expert care teams work with you on personalized care plans that work for your child and for you.

VIRTUAL CARE FROM ANYWHERE

Access confidential video visits plus on-demand chats, tips & resources, and interactive exercises in Brightline Connect+.

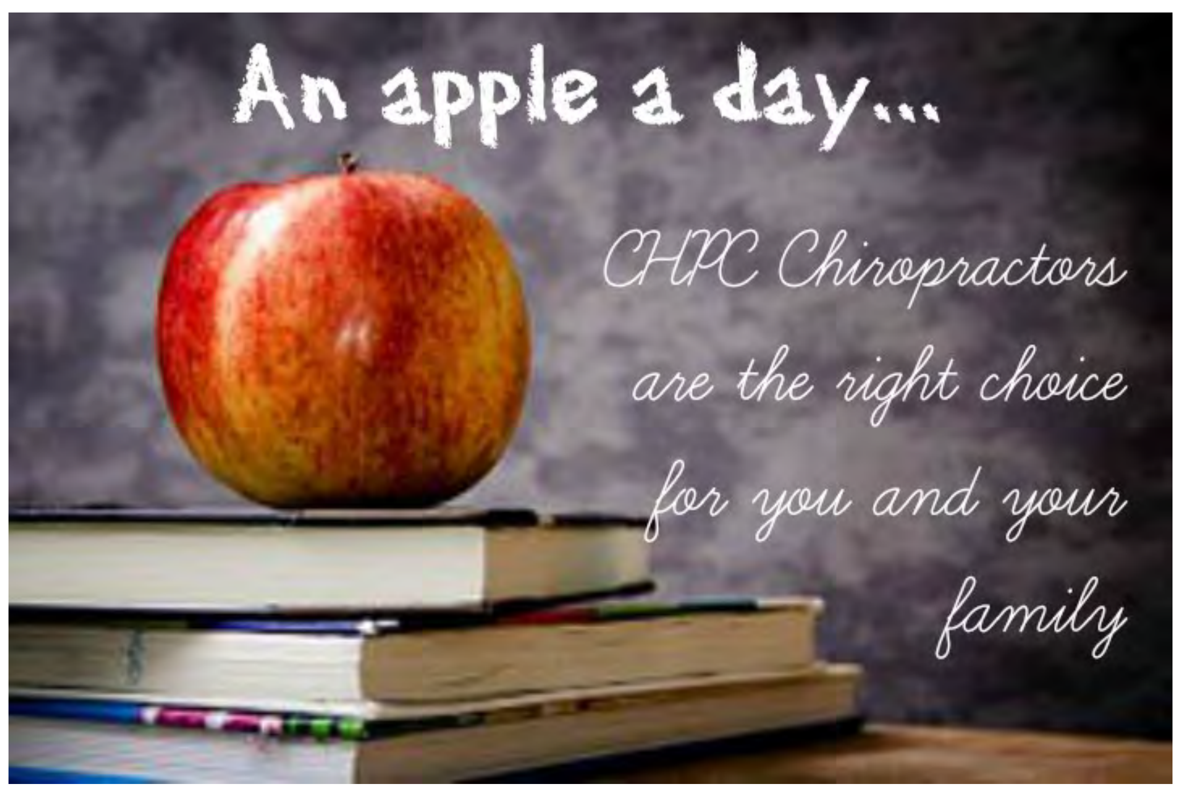


Questions? Get in touch with Brightline Member Support

888-224-7332 **care@hellobrightline.com**

All clinical services are provided by licensed physicians and clinicians practicing within independently owned and operated professional practices. These are known as Brightline Medical Associates, PA, Brightline Medical Associates of California, Inc., Brightline Medical Associates of New Jersey, and Brightline Medical Associates of Kansas, Inc. Brightline, Inc. does not itself provide any physician, behavioral health professional, or other healthcare provider services.

MCSIG & Rx Plan Benefits - Chiropractic



Your MCSIG benefits include some of the best chiropractic coverage available

Adjustments, therapeutic treatments (excluding massage) and in-office diagnostic x-rays

Find a CHPC provider at: www.chpc.com or call (800) 995-2442

MCSIG & Rx Plan Benefits - Wellvolution

Wellvolution

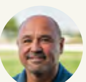
We want you to live your healthiest lifestyle. That's why it's important our community has access to tools and programs to help manage stress, lose weight, prevent disease, or treat existing conditions.

1. Wellvolution analyzes your health goals to create a plan just for you, with digital tools and weekly action plans

2. Track and monitor progress toward your health goals — with one-on-one support from experts when you need it

3. Feel better and start living your healthiest life

Programs include:



"This program has changed my life for the better! I feel like a new man with more energy, less stress, better sleep and I don't have to use my sleep apnea machine anymore!"

- Angel, Wellvolution member

"I cannot say enough about this program. It has changed my life! I have been on this program for 3 months now, I've lost 30 pounds, I don't need to take cholesterol medicine anymore!"

- Kim, Wellvolution member

Change your health, change your life. Visit **wellvolution.com** to get started today.

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W-00014-09-21

Dental

When it comes to choosing a dental plan, you want benefits that fit the needs of you and your family. Delta PPO offers comprehensive dental coverage, quality care, and excellent customer service.

Delta Dental

Delta Dental, our preferred provider organization (PPO) plan, provides access to the largest PPO dentist network in the U.S. Delta Dental dentists agree to accept reduced fees for covered procedures when treating PPO patients. This means your out-of-pocket costs are usually lower when you visit a PPO dentist than when you visit a non-Delta Dental dentist, but you have the freedom to visit any licensed dentist, anywhere in the world.

San Luis Obispo County Community College District offers four comprehensive dental plans for eligible employees through Delta Dental. There is a two-year enrollment commitment; you will not be allowed to cancel coverage until you have been on the plan for two years. If you do cancel your coverage, you will not be allowed to re-enroll for two years.

Benefits and Covered Services*	Benefit Highlights – Delta Dental PPO			
	Plan A	Plan B	Plan C	Plan D
Who is Eligible	Primary enrollee, spouse/domestic partner and eligible dependent children to age 26			
Deductibles *(per plan year)*				
• Individual	$50	$50	$50	$50
• Family	$150	$150	$150	$150
Deductible Waived for Diagnostic and Preventive	Yes	Yes	Yes	Yes
Annual Maximum Benefit				
• In-Network *(Calendar year per person)*	$1,400	$2,000	$2,400	$3,000
• Out-of-Network *(Calendar year per person)*	$1,200	$1,800	$2,200	$2,800
Waiting Period(s)				
• Basic Benefits	None	None	None	None
• Crown and Casts	None	None	None	None
• Orthodontist	None	None	None	None

* Limitations or waiting periods 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.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the Plan Documents will prevail.

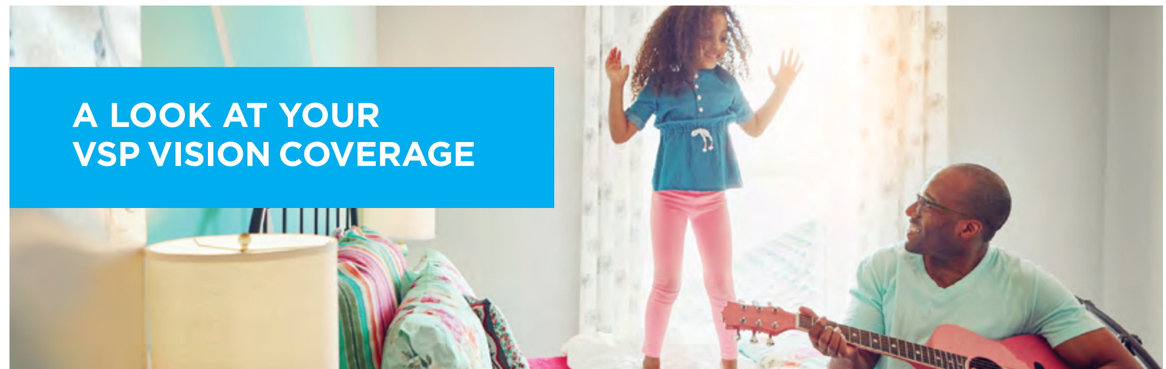
Benefits and Covered Services*	Benefit Highlights – Delta Dental PPO							
	Plan A		Plan B		Plan C		Plan D	
	Delta Dental PPO Dentist**	Non-Delta Dental Dentist	Delta Dental PPO Dentist**	Non-Delta Dental Dentist	Delta Dental PPO Dentist**	Non-Delta Dental Dentist	Delta Dental PPO Dentist**	Non-Delta Dental Dentist
Diagnostic and Preventive Benefits *(Oral Exams, [2] Routine Cleanings, X-Rays, Fluoride Treatment, Space Maintainers, Specialist Consultations)*	100%	100%	100%	100%	100%	100%	100%	100%
Basic Benefits *(Fillings, Root Canals, Periodontics [Gum Treatment], Tissue Removal [Biopsy], Oral Surgery [Extractions])*	100%	100%	100%	100%	100%	100%	100%	100%
Crowns, Other Cast Restorations *(Crowns, Inlays, Onlays and Cast Restorations)*	80%	80%	80%	80%	100%	100%	100%	100%
Prosthodontics *(Bridges, Partial Dentures, Full Dentures)*	80%	80%	80%	80%	80%	80%	80%	80%
Orthodontics *(Dependent Children)*	50% Subject to a $500 calendar year maximum per person		50% Subject to a $1,000 calendar year maximum per person		50% Subject to a $500 calendar year maximum per person		50% Subject to a $1,000 calendar year maximum per person	

* Limitations or waiting periods 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.

** Fees are based on maximum plan allowance (MPA) for in-network dentists and the MPA for out-of-network dentists. Reimbursement is paid on Delta Dental contract allowances and not necessarily each dentist's actual fees.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the Plan Documents will prevail.

Vision



SEE HEALTHY AND LIVE HAPPY WITH HELP FROM SAN LUIS OBISPO CCD AND VSP.

As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.
With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

Like shopping online? Go to **eyeconic.com**® and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses.

QUALITY VISION CARE YOU NEED.
You'll get great care from a VSP network doctor, including a WellVision Exam®. This comprehensive eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

Contact us: **800.877.7195** or **vsp.com**

YOUR VSP VISION BENEFITS SUMMARY
SAN LUIS OBISPO CCD and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$0	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES			
FRAME	• $220 featured frame brands allowance • $200 frame allowance • 20% savings on the amount over your allowance	$0	Every 12 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	$0	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every 12 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Routine Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		
YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS			
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.			

Coverage with a retail chain may be different or not apply. Log in to **vsp.com** to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Classification: Restricted

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VSP, VSP Vision Care for life, Eyeconic, and WellVision Exam are registered trademarks. Flexon is a registered trademark of Marchon Eyewear, Inc. All other brands or marks are the property of their respective owners.

Metlife Life Insurance

As a MCSIG Member you qualify for a FREE $25,000 Life Insurance Policy!

- **MCSIG Eligible Employees:** You already have a Free Metlife Life Insurance policy of $25,000. If you are interested in this free coverage, please fill out the Beneficiary Form found at: https://www.cuesta.edu/about/depts/benefits-insurance/Classified_Management_Medical.html and return it to the Human Resources Department.

The Beneficiary Form protects your family and is a very important document for Cuesta College to have on file to ensure that your benefits are paid.

Arranged By:
Keenan

DID YOU KNOW...

As a Cuesta College employee you qualify for a FREE $2,000 AD&D Insurance Policy!

- **All Employees:** You are entitled to a free Metlife AD&D Insurance policy of $2,000.00. If you are interested in this free coverage, please complete the beneficiary section on the free Metlife AD&D option in your Benefit Bridge account.

The Beneficiary Form protects your family and is a very important document for Cuesta College to have on file to ensure that your benefits are paid.

Arranged By:
Keenan

Optional Life and AD&D

This schedule shows the benefits that are available under the voluntary MetLife Policy. You and your dependents will only be insured for the benefits:

- for which you and your dependents become and remain eligible;
- which you elect, if subject to election; ***and***
- which are in effect.

This plan is only available for employees working 50% and above.

Plan Benefits	Optional Life Insurance	Optional AD&D Insurance
For Active Employees	Increments of $10,000	Option 1: $10,000 Option 2: $25,000 Option 3: $50,000 Option 4: $100,000 Option 5: $250,000 Option 6: $500,000
Accelerated Benefit Option	Up to 25% of your Basic Life amount; not to exceed $250,000	N/A
Maximum Life Benefit	Lesser of 5x salary or $500,000	$500,000
DEPENDENTS		
For Your Spouse	Increments of $10,000 up to a maximum of $500,000	60% of employee amount
For Each of Your Children		
• Children	Option 1: $2,500 Option 2: $5,000 Option 3: $10,000	25% of employee amount; maximum of $50,000

Guaranteed Issue Plan Amounts (For New Hires Only): Employee $100,000 (Or 2x salary, not to exceed $100,000), Spouse $60,000, Child(ren) $25,000. Larger plan amounts for new hires, and all existing employees who elect a new coverage amount, will need to go through the Evidence of Insurability process for approval.

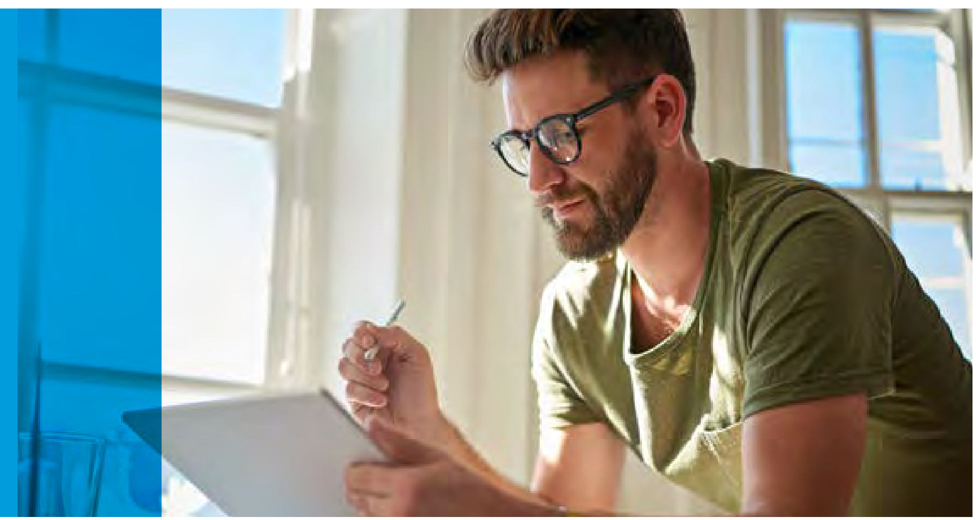
The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

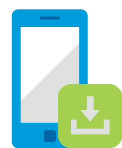
Employee Assistance Program

Professional support and guidance for everyday life

Life doesn't always go as planned. And while you can't always avoid the twists and turns, you can get help to keep moving forward.

We can help you and your family, those living at home, get professional support and guidance to make life a little easier. Our Employee Assistance Program (EAP) is available to you in addition to the benefits provided with your MetLife insurance coverage. This program provides you with easy-to-use services to help with the everyday challenges of life — at no additional cost to you.





Help is always at your fingertips.

Our mobile app makes it easy for you to access and personalize educational content important to you.

Search "LifeWorks" on iTunes App Store or Google Play. Log in with the user name: **metlifeeap** and password: **eap**

Expert advice for work, life, and your well-being

The program's experienced counselors provided through LifeWorks — one of the nation's premier providers of Employee Assistance Program services — can talk to you about anything going on in your life, including:

- **Family:** Going through a divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Job relocation, building relationships with co-workers and managers, navigating through reorganization
- **Money:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- **Legal Services:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning
- **Identity Theft Recovery:** ID theft prevention tips and help from a financial counselor if you are victimized
- **Health:** Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- **Everyday Life:** Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet

Convenient and confidential help when you want it, how you want it

Your program includes up to 5 in person, phone or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year. You can call **1-888-319-7819** to speak with a counselor or schedule an appointment, 24/7/365.

When you call, just select "Employee Assistance Program" when prompted. You'll immediately be connected to a counselor.

If you're simply looking for information, the program offers easy to use educational tools and resources, online and through a mobile app. There is a chat feature so you can talk with a consultant to guide you to the information you are looking for or help you schedule an appointment with a counselor.

Log on to metlifeeap.lifeworks.com, user name: metlifeeap and password: eap

Navigating life together

Employee Assistance Program (EAP) (continued)

Answers to important questions

Are Employee Assistance Program services confidential?
Yes. Any personal information provided to LifeWorks stays completely confidential.*

How do I get help?
Getting professional help is just a phone call away. Simply call 1-888-319-7819 to speak with a counselor or to schedule an in person, phone or video conference appointment. These services are available 24 hours a day, 7 days a week.

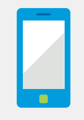
When is the right time to call?
That's up to you. Counselors are here whenever you need them —whether you simply need to talk or want guidance on something you are going through.

Is my Employee Assistance Program included with my MetLife coverage?
Yes. There is no cost to you because your employer pays for the services provided within our program. While we offer a broad range of services, there may be some assistance that's not included. You can still work with counselors for these services by arranging to pay for them directly.

Does the program have any limitations?
While we offer a broad range of services, we may not cover all services you may need. Your Employee Assistance Program does not provide:

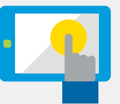
- Inpatient or outpatient treatment for any medically treated illness
- Prescription drugs
- Treatment or services for intellectual disability or autism
- Counseling services beyond the number of sessions covered or requiring longer term intervention
- Services by counselors who are not LifeWorks providers
- Counseling required by law or a court, or paid for by Workers' Compensation

When you need some support, we're here to help.



Phone
1-888-319-7819

Web
metlifeeap.lifeworks.com
user name: metlifeeap
and password: eap



Mobile App
user name: metlifeeap
and password: eap

*MetLife and LifeWorks abide by federal and state regulations regarding duty to warn of harm to self or others. In these instances, the consultant may have a duty to intervene and report a situation to the appropriate authority.

Some restrictions may apply to all of the above-mentioned services. Please contact your employer or MetLife for details.

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
OPT2/3 L0219512255[exp0220][All States][DC,GU,MP,PR,VI] © 2019 MetLife Services and Solutions, LLC

Disability | Group Benefits

Employee Assistance Program (EAP) Employer Reference Guide – Premier Option

Up to **5 in person counseling sessions** including Critical Incident Stress Management (CISM) and eight (8) training hours annually

Support for Employees

Integrated services, including

- Educational Materials
- Resources and Personalized Researched Referrals
- Manager Services – access by managers and supervisors to qualified EAP consultants for management consultation on workplace concerns
- EAP Consultation – access to qualified EAP consultants for information, support, crisis intervention, educational materials in electronic format, and referral to local resources and assistance
- EAP Sessions – assessment and short-term problem resolution by network of qualified EAP consultants. Up to five (5) sessions provided. If it is determined that the presenting clinical issue is not appropriate for short-term counseling, the participant will be referred to the appropriate resources

Work-Life Services

- Work-Life Consultation – access to qualified consultants for information, assessment, action planning and resources, educational materials in electronic format, and referral to local resources and assistance in areas like:
  - Parenting, Eldercare and aging
  - Consumer and community needs
  - Education
  - Disability
  - Adoption
  - Referrals matched and confirmed for vacancies for child care and elder care
  - Emotions and stress
  - Workplace issues

Financial Services

- Financial Consultation – access to qualified consultants for information, assessment, action planning and resources, educational materials in electronic format, and referral to local resources and assistance
- Financial Professional Consultation – access to consultation with certified financial professionals; LifeWorks does not provide investment advice or loan funds

Legal Services

- Access to qualified consultants for information, assessment, action planning and resources, educational materials in electronic format, and referral to local resources and assistance
- Network Attorney Consultation – access to consultation with network attorneys delivered via telephone or in-person to include up to thirty (30) minutes of consultation per legal issue ("Initial Attorney Consultation"). LifeWorks does not provide legal advice or representation, or review of real estate or trust documents; Discount on Attorney Services – following Initial Attorney Consultation, discount off standard legal fees as offered by LifeWorks' network of attorneys

Identity Theft Recovery Services

- This service includes a telephonic consultation up to sixty (60) minutes in length with a Financial Counselor who will help the Member to determine if the Member was a victim of identity theft and recommend options on how to place fraud alerts, freeze credit, file police reports, and conduct other activities necessary to resolve fraud. General information on identity theft prevention is also available

Call: 1-888-319-7819

LifeWorks Mobile App:
Apple & Android Stores
User ID: metlifeeap
Password: eap

Website:
metlifeeap.lifeworks.com
User ID: metlifeeap
Password: eap

metlife.com

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

Employee Assistance Program (EAP) (continued)

Telephonic Life Coaching

- Access to life coaches who are Masters level counselors/consultants with disciplines in social work, counseling and psychology,); are board certified coaches (BCCs) and are credentialed through the (CCE) Center for Credential and Education. Each coach received their training from the ILTC (Institute for Life Coach Training)
- Ability for participants to partner with a life coach to help address issues, overcome obstacles and attempt to achieve goals agreed to between the life coach and the Participants

Support for your Managers

Initial Onboarding Orientation

- Access to employee program orientation – including recorded sessions, communications and web based delivery of scheduled training on the suite of services available through LifeWorks

Management Orientation

- Access to manager program orientation – including recorded sessions, communications and web based delivery of scheduled training on the suite of Services available through LifeWorks. In addition to Services featured in the employee orientation, the manager orientation will have information on services available through Management Line- including but not limited to formal referrals, SAACM, CISM and workplace management support

Training Sessions

- Employers access to eight (8) hours in every year of their contract that can be applied toward trainings or orientations annually. In case of any hours remaining unused in any such period, they will lapse and cannot be carried over to the following year

Substance Abuse Assessment and Case Management ("SAACM")

Access to specially trained EAP consultants for consultation for managers and human resources regarding employer- initiated substance abuse referrals. The service also offers a telephonic assessment of the severity of the employee's substance use completed by Masters level consultants with Substance Abuse training and experience. Case management also includes program referrals, compliance monitoring, and status reports to the Designated Employer Representative (DER) for up to one year from initial contact date (or until recommendations are completed). Face to Face assessments to satisfy Department of Transportation (DOT) substance abuse violations are also offered at an additional cost

LifeWorks Website - www.metlifeeap.lifeworks.com

- A comprehensive and flexible array of resources through one Web site and app with resources and tools focused on helping Participants' with their work and personal lives
  - Educational Resources
  - Interactive Tools and Assessments
  - User Friendly Interface
  - Online Resources and Assistance – in areas including but not limited to emotional health, addictions, workplace issues, parenting, elders and aging, consumer & community needs, education, disability, adoption, financial needs, legal needs, and health

LifeWorks Mobile Application

Search for "LifeWorks" on the Apple or Android App Stores

LifeWorks Onsite Services – Included in the PEPM Fee (unless otherwise indicated).

- Critical Incident Stress Management (CISM): CISM is a comprehensive trauma management service provided by specially trained consultants, which is available 24/7 365 days a year via the toll free line. The service includes management consultations as well as the coordination for onsite critical incident response for events including; sudden death, anticipatory grief, workplace accidents, and natural disasters
- Organizational Change Group Event(s)-: (non CISM) Fee for Service – Is a comprehensive trauma management service provided by specially trained consultants, which is available 24/7 365 days a year via the toll free (800) line. The service includes management consultations as well as the coordination for onsite support for non "CISM" events, which are normally pre planned
- Organizational Change Individual Event(s)-: (non CISM) Fee for Service – Is a comprehensive trauma management service provided by specially trained consultants, which is available 24/7 365 days a year via the toll free line. The service includes management consultations as well as the coordination for onsite support for non "CISM" events involving one individual, which are normally pre planned

AMERICAN FIDELITY ASSURANCE COMPANY

Cuesta College

Benefits Overview

Central California Branch Office
3649 W. Beechwood Ave., Suite 103
Fresno, CA 93711
866-504-0010 · 559-230-2107
americanfidelity.com

SB-30560-0816

Cuesta College

Dear Cuesta College employee:

Out of all the items on your to-do list, enrolling in your employer's benefits program likely isn't at the top. But it's more significant than you may think, as protecting yourself and your family is vitally important.

That's where we come in. American Fidelity provides financial solutions to employees just like you, and we offer benefits tailored for your specific needs.

Your benefit program includes a Section 125 Plan, which not only allows you to pre-tax premiums for qualified benefits, it also allows you to enjoy a tax-saving way to pay for eligible medical or dependent day care expenses with a reimbursement account that deducts pre-tax dollars from your paycheck. Simply choose the amount to be deducted, and the funds are set aside to be used for eligible expenses throughout the year. You can choose from several types of plans.

You only have one chance each year to get educated on all available benefit options and choose the ones that best meet your needs. And because benefits can be confusing, we're here to help you every step of the way. We'll walk you through all available options, answer any questions you may have, and help you build a package that's perfect for you.

An interest form is attached for you to complete and return, and a representative will touch base with you soon to discuss your available options.

Sincerely,

American Fidelity Assurance Company

For more information, contact your local American Fidelity representative.

American Fidelity, a different opinion in employee benefits.

Central California Branch Office
3649 W. Beechwood Ave., Suite 103
Fresno, CA 93711
866-504-0010 · 559-230-2107
americanfidelity.com

SB-30534-0716

Cuesta Community College

Plan for tomorrow, today.

Everyone knows health insurance doesn't pay for everything. Do you feel fully protected? Reviewing and updating your coverage each year is important.

Get help with your options. Stop by and see an American Fidelity account manager.

Accident Only Insurance

AF™ **Limited Benefit Accident Only Insurance**

- may help manage out-of-pocket costs to treat injuries resulting from a covered accident
- provides benefit payments directly to you

americanfidelity.com/info/accident

Cancer Insurance

AF™ **Limited Benefit Individual Cancer Insurance**

- may help ease the financial burden of cancer treatment, so you can focus on recovery
- provides benefit payments directly to you

americanfidelity.com/info/cancer

Disability Income Insurance

AF™ **Disability Income Insurance**

- can help protect your finances in case of a covered injury or illness
- provides a benefit to help cover costs while you are unable to work
- pays some of your gross monthly earnings

americanfidelity.com/info/disability

Life Insurance

AF™ **Life Insurance** may help ensure your family is financially protected in the event of a loss. You own the policy, so you can take it with you to a different job or into retirement.

americanfidelity.com/info/life

EMPLOYER BENEFIT
SOLUTIONS
FOR EDUCATION

Each year, about **2.8 million children** between the ages of 5 and 14 are treated for sports and recreational-related injuries.

National Safety Council, Injury Facts; 2019 Web.

Critical Illness Insurance

AF™ Limited Benefit Critical Illness Insurance

- pays a benefit upon diagnosis of certain covered life-altering illnesses
- helps with costs not covered by medical insurance

americanfidelity.com/info/critical-illness

Hospital Indemnity Insurance

AF™ Limited Benefit Hospital Indemnity Insurance

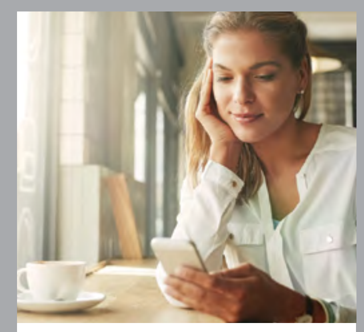
- helps pay for out-of-pocket costs, like a hospital stay
- when used with a Health Savings Account allows for a tax benefit and potential savings

americanfidelity.com/info/hospital-indemnity

Dependent Care Accounts

- allow you to repay yourself for eligible dependent care costs incurred during the plan year
- let you withhold your money from your paycheck, pre-tax, reducing your overall tax burden

americanfidelity.com/info/fsa



Educational Videos

Through short videos, we offer multiple ways to learn about your benefits options.

This video library includes enrollment tips, insurance information, stories, and support options.

americanfidelity.com/videos

Flexible Spending Accounts

Everyone likes saving money.

Flexible spending accounts (FSA) allow you to save part of your paycheck, before taxes, to pay for eligible costs throughout the year.

Types of Accounts

- Healthcare FSAs
- Limited Purpose FSAs
- Dependent Care Accounts

Explore your savings options at americanfidelity.com/info/fsa

To calculate medical costs that may not be covered by insurance, visit americanfidelity.com/fsa-worksheet

Examples of Eligible Expenses

- Asthma treatments
- Chiropractic care
- Contact lenses
- Copays
- Dental services
- Eye exam/eyeglasses
- Fertility treatments
- Laser eye surgery
- Over-the-counter bandages
- Physical exams
- Physical therapy
- Prescriptions
- Prenatal care
- Sunscreen with 15 SPF or higher
- Walkers/wheelchairs

americanfidelity.com/eligible-expenses

American Fidelity (continued)

Annuities

It's never too early to plan for retirement.

When you think about your retirement, do you envision opportunities to travel, learn a new hobby, or spend time with family? No matter your retirement goals, it's important to start saving early.

Even with government retirement systems, you may need to consider personal retirement options to make the best of your golden years.

That's where annuities—or retirement savings plans—can help.

How It Works:

1. **Select** the right account for you
2. **Determine** a contribution amount
3. **Contribute** from your paycheck
4. **Monitor** your investment performance

When it comes to your retirement, it's important to save early and often. Learn more about retirement savings plans at americanfidelity.com/info/annuities.

File Your Claims Faster

AFmobile®

Our mobile app is the easiest way to submit your claims and documentation. Upload documentation* directly from your device's picture gallery.

americanfidelity.com®

Filing online is convenient, secure, and provides faster claim processing than filing by paper. From your laptop or desktop, log in to file a claim and upload documentation*.

Need assistance?

Visit americanfidelity.com/fileaclaim

**The Internal Revenue Code regulations require proof of eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.*

Cuesta Community College

24/7 Access with AFmobile®

Manage your insurance benefits and reimbursement accounts all from the palm of your hand.

View
account balances

Manage
claims and reimbursements

Submit
documentation

Receive
alerts

Maintain
personal information

Get Started

Register at americanfidelity.com/register or **download AFmobile** and select the New User link.

Please allow one business day after you enroll before registering for an online account. If you already have an account, your username and password will be the same for AFmobile.

Central California Branch Office
3649 W. Beechwood Ave., Suite 103
Fresno, CA 93711
866-504-0010 · 559-230-2107
SB-33041-0120

Limitations, exclusions and waiting periods may apply.

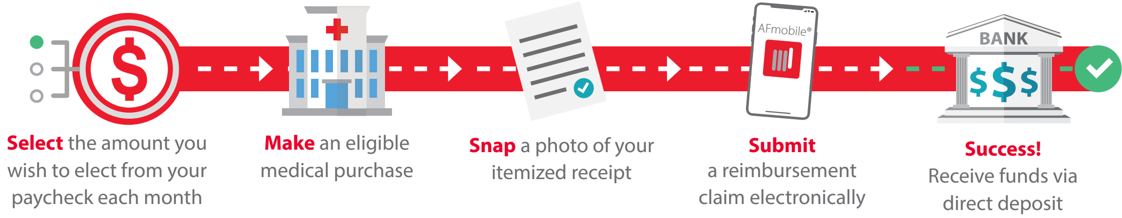
Flexible Spending Accounts

Plan Today for Tomorrow's Costs.

With medical costs continuing to rise, tools to help manage out-of-pocket medical expenses can be a popular choice.

One option is a Healthcare Flexible Spending Account (HCFSA). Healthcare FSAs allow you to set aside money tax-free for eligible medical costs, such as doctor visits, prescription drugs, prescription contact lenses, and dental procedures. Additionally, your entire election amount is available to you at the beginning of your plan year.

Here's How It Works



Select the amount you wish to elect from your paycheck each month

Make an eligible medical purchase

Snap a photo of your itemized receipt

Submit a reimbursement claim electronically

Success! Receive funds via direct deposit

Learn how to file reimbursement claims at **americanfidelity.com/fileaclaim**

Paycheck Savings Example

In the example to the right, Jane makes $4,000 per paycheck and is paid monthly. By participating in an HCFSA, she would save $82.96 a month.

That's a savings of $995.52 a year.

To calculate your possible savings, visit **americanfidelity.com/s125-calculator**

Earnings & Hours	Without FSA	With FSA
Gross Pay	$4,000	$4,000
Health Insurance	-$300	-$300
Health FSA Contribution	*N/A*	-$300
Taxable Income	***$3,700***	***$3,400***
Taxes (Federal & State @ 20%)	-$740	-$680
Less Estimated FICA (7.65%)	-$283.05	-$260.10
Out-of Pocket Medical Expenses	-$300	*N/A*
Take Home Pay	***$2,376.95***	***$2,459.90***

Examples of Eligible Expenses

- Over-the-counter drugs and medicines without a prescription
- Prescription contacts
- Prenatal care
- Copays/Co-insurance
- Physical exams
- Asthma treatments
- Dental services
- Laser eye surgery
- Chiropractic care
- Eye exams/eyeglasses
- Physical therapy
- Deductibles
- Menstrual products

For a list of eligible expenses visit americanfidelity.com/eligible-expenses

Flexible Spending Accounts

Internal Revenue Code (IRC) Requirements

IRC guidelines are strict where tax breaks are made available. As your plan provider, we are required to follow IRC rules.

First, the money you set aside operates under a "use or lose" system. That means you'll want to use all of your funds prior to the next plan year or you will lose whatever amount is left.

Ask if your employer's plan includes a Runoff Period and Carryover Provision or Grace Period.

- **Runoff Period**
  A period typically up to 90 days after the plan year ends when you can submit claims that you incurred during the previous plan year, but have not been submitted for reimbursement.

- **Carryover Provision**
  This provision allows you to carry over up to $550 of unused contributions from one plan year to the next.

- **Grace Period**
  An additional two and a half months following the end of the plan year in which you can incur claims and receive reimbursement.

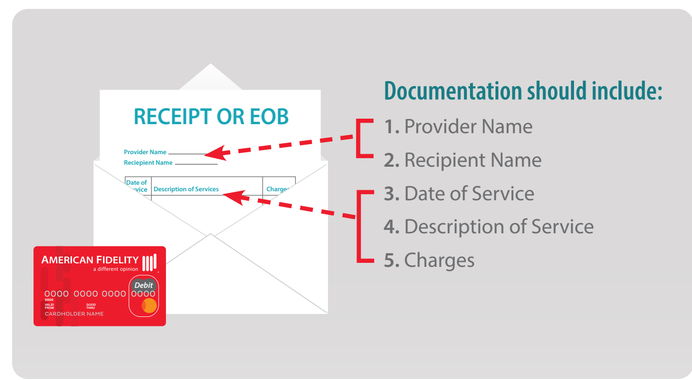
Second, the IRC requires proof for eligible expenses. For expenses that aren't validated at the time of debit card swipe, an itemized receipt or Explanation of Benefits (EOB) must be submitted to prove eligibility of the expense. Submitting documentation through AFmobile® or online is the fastest way to validate a claim.

Using your Benefits Debit Card

A Benefits Debit Card allows you to pay for eligible medical expenses using the funds in your Healthcare FSA. The card may be used at locations who accept Mastercard® and have been identified as an authorized medical merchant.

To verify transactions, submit an EOB or itemized receipt after your transaction or if you receive a documentation request letter.

Learn more about your debit card at **americanfidelity.com/debit-card**



SB-32928-1120

Contact Information

Below is a listing of the toll-free numbers you may call with questions about the plans available to you. You may also use the website to access information from providers.

Plan	Phone Number	Website/Email
Medical		
• Blue Shield	MCSIG 800.287.1442	www.blueshieldca.com/MCSIG
Dental		
• Delta Dental	888.335.8227	www.deltadentalins.com
Vision		
• VSP	800.877.7195	www.vsp.com
EAP, Voluntary Life and AD&D		
• MetLife	800.METLIFE	www.metlife.com
Retirement		
• PERS	888.225.7377	www.calpers.ca.gov
• STRS	800.228.3870	www.calstrs.com
Section 125		
American Fidelity		
• Corporate Office	800.654.8489	www.americanfidelity.com
• Fresno Office	559.230.2107	afes-fresnobranch@americanfidelity.com
Investment		
• Envoy Plan Services	800.248.8858	www.envoyplanservices.com
• Dan Buster, Financial Advisor	909.247.1112	dbuster@zukfinancial.com

Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for certain out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws, can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn generally may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 805.546.3129.

Patient Protections

The medical plan requires 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 plan 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, visit www.blueshieldca.com.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) 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, visit www.blueshieldca.com.

The major medical plans described in this booklet have provider networks with Blue Shield. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims, and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

Notice of Extended Coverage to Children Covered as Students

"Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who, as a condition of coverage, is enrolled in an institution of higher education. Please review the following information with respect to your dependent child's rights in the event student status is lost.

Michelle's Law requires the Plan to allow extended eligibility in some cases for a covered child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child means a child who is a dependent of a plan participant and who is eligible under the terms of the Plan based on their student status and enrollment at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.*
- *Medically necessary leave of absence means a leave of absence or any other change in enrollment:*
  - Of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
  - Which is medically necessary; and,

- Which causes the dependent child to lose student status under the terms of the Plan.

The dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- *One year after the first day of the leave of absence; or*
- *The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).*

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

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

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

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

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number and Social Security Number; the full name, address, phone number and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

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

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

Important Notices (continued)

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Human Resources
805.546.3129
P O Box 8106
San Luis Obispo, CA 93403-8106
HR@Cuesta.edu

Medicare Part D – Important Notice 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 Cuesta 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:

- **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.**
- **Blue Shield has determined that the prescription drug coverage offered by** Cuesta 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 current Cuesta College coverage will not be affected. If you keep this coverage and elect Medicare, the Cuesta College coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Cuesta College coverage, be aware that you and your dependents will be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Cuesta 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 (i.e., 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 will 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 Cuesta 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 will 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 www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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 www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

REMEMBER

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

Date:	01/01/2023
Name of Entity / Sender:	Cuesta College
Contact:	HR
Address:	P O Box 8106 San Luis Obispo, CA 93403
Phone:	805.546.3129

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Cuesta College Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources
805.546.3129
P O Box 8106
San Luis Obispo, CA 93403-8106
HR@Cuesta.edu

Important Notice Regarding Wellness Information

The MCSIG/Blue Shield Wellness Program is a voluntary program available to all employees and is subject to federal law including the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.

If you choose to participate, you may be asked to complete a voluntary health risk assessment that asks questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You may also be asked to complete a voluntary biometric screening.

The information gathered from your health risk assessment and/or biometric screening will be used to provide you with information to help you understand your current health, potential risks, and may also be used to offer you services through the wellness program. You are also encouraged to share your results or concerns with your own doctor.

The law requires us to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Cuesta College may use aggregate, non-employee-specific information to design a program to address health risks in the workplace, your personal identifiable information will never be disclosed publicly or to your employer. Medical information that personally identifies you in connection with the wellness program will not be disclosed to your supervisors or managers and will never be used to make decisions regarding your employment. Anyone (e.g., a registered nurse, a doctor, health coach, etc.) who receives information about you for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

If you have any questions or concerns, please contact HR at HR@Cuesta.edu.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about MCSIG/Blue Shield in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California will begin November 1, 2022, and is anticipated to end on January 31, 2023. Open Enrollment for most other states will begin on November 1 and close on January 15 of each year. Some states have expanded the open enrollment period beyond January 15, 2023 for coverage to begin in 2023. Notably, Covered California continues its special enrollment periods for coverage beginning in 2023.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not “Affordable,” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.12% (for 2023) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s medical plan. If you receive a premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

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

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name Cuesta College	**4. Employer Identification Number (EIN)** 52-2018681	
5. Employer address P O Box 8106	**6. Employer phone number** 805.546.3129	
7. City San Luis Obispo	**8. State** CA	**9. ZIP code** 93403
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	**12. Email address** HR@Cuesta.edu	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

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 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 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: 855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
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 (CHIP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877-357-3268

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

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

Important Notices (continued)

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 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: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877-524-4718
Medicaid Website: https://chfs.ky.gov

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

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 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: 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: 800-657-3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084
Email: HHSHIPPProgram@mt.gov

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

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP Program Toll-Free Phone: 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: 800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 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: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp/
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-Free Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 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
866-444-EBSA (3272)

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

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, covering preventive care without cost-sharing, etc., among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children's Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid, but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g., primary care office, hospital), will make the claim on your behalf.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Glossary (continued)

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year-to-year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Open Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Open Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured-so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Click here to watch a video on Benefits Key Terms Explained.

Notes