2022 -2023 BENEFITS OVERVIEW

10/01/2022 – 09/30/2023

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MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the *Important Plan Information* section on pages 42-43 for more details.

The information in this guide is a general outline of the benefits offered under Pasadena City College benefits program. Specific plan details, eligibility definitions, limitations and exclusions are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), Certificate and/or insurance Policies. The plan documents contain the relevant plan provisions. If the information in this guide differs from the plan documents, the plan documents will prevail.

WELCOME TO YOUR BENEFITS GUIDE

2022-2023 BENEFITS

The benefits in this guide are effective October 1, 2022 through September 30, 2023

At Pasadena City College, we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future.

Pasadena City College pays 100% of medical, dental, and vision benefits for all full-time employees and their eligible dependents.

This guide provides an overview of your healthcare coverage, life, voluntary benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life.

Review the coverage and tools available to you to make the most of your benefits package.

Who's Eligible for Benefits?

Dependent Verification

Adding dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Prior year's tax return and marriage certificate.
- State-issued certificate of domestic partnership.
- Birth certificate.
- Final decree of divorce.
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship.
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support).

If you do not supply the proper documentation to add dependents within 30 day period, you will not be able to add the dependent(s) until the next open enrollment period.

Employees

You are eligible for the benefits outlined in this guide if you are a full-time employee.

Eligible dependents

- Legally married spouse or registered domestic partner.
- Your children (including your domestic partner's children) up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

Who is not eligible

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings
- Ex-Spouse or Ex-Domestic Partner

For additional information, please refer to the plan document for each benefit.

Enrolling for Benefits

When can you enroll

Open enrollment is an annual opportunity during which employees can make changes to their benefit elections without a qualifying life event. Life events include (but are not limited to):

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

If you qualify for a mid-year benefit change, you will be required to submit proof of change.

Changes must be submitted to the Benefits team within 30 days of the life event. An employee may be held responsible for substantial charges if services are provided for a person who is found to be ineligible.

Eligible New Hires

You must complete the online enrollment or waiver process, and upload dependent verification documentation within 30 days from your date of hire. If documentation is not received, your dependent(s) will not be enrolled.

Online Benefits Website: Benxcel Platform

Coverage for new full-time employees begins on the first of the month following or coinciding with the date of hire.

How to Enroll or Waive Benefits

Go online to our Benefits website: Benxcel Platform. The username and password are your LancerPoint (PCC) credentials. After you login, you will be asked to review and update your employee profile. Make sure all the information about yourself and dependent(s) is correct. Don’t forget to upload dependent verification documentation. If documentation is not received, your dependent(s) will not be enrolled.

If you have login problems contact the Benefits team.

Eligibility Documentation Chart

The following verification documents are required to enroll a dependent in health benefit plans. SISC requires the Social Security Numbers for all dependents to be covered on the plans and reserves the right to request additional documentation to substantiate eligibility.

Dependent Type	Required Documentation
Spouse	• Prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out). • For newly married couples where prior year tax return is not available, a marriage certificate will be accepted.
Domestic Partner	• Certificate of Registered Domestic Partnership issued by the State of California (Enrolling a Domestic Partner may cause the employer contribution to become taxable)
Children, Stepchildren, and/or Adopted Children up to age 26	• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name, and child's DOB) • Legal Adoption Documentation
Legal Guardianship up to age 18	• Legal U.S. Court Documentation establishing Guardianship
Disabled Dependents over age 26	**Anthem Blue Cross (All items listed below are required)** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Anthem Disabled Dependent Certification Form **Kaiser (All items listed below are required)** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Disabled Dependent Enrollment Application • Most recent Kaiser Certification notice (if available)
Retirees and/or Dependents on a Retiree Plan Age 65 or Over	• Proof of enrollment in Medicare Part A & Part B (copy of current Medicare card or Medicare enrollment confirmation letter showing effective dates of Part A and Part B)

Changing Your Benefits

LIFE HAPPENS

A change in your life may allow you to update your benefit choices.

Three rules apply to making changes to your benefits during the year:

1. Any change you make must be consistent with the change in status;
2. You must notify the Benefits team within 30 days of the date the event occurs; and
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.)

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a qualifying life event or qualify for "special enrollment." If you qualify for a mid-year benefit change, you will be required to submit proof of the change.

The following are considered qualifying life events:

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

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

MEDICAL

OUR PLANS

Kaiser Traditional HMO

Anthem Premier HMO

Anthem 100-A PPO Classified

Anthem 100-A PPO Certificated

Anthem Anchor Bronze PPO

Anthem Minimum Value PPO

WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs, favorite doctors, and budget. No matter which plan you select, Pasadena City College pays 100% of the monthly premium, if you are a full-time employee. Here are some considerations.

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

Kaiser Medical Traditional HMO

This plan is available only in certain California counties and cities ("Service Area") as described in the Evidence of Coverage. You must live and/or work in this select Service Area in order to enroll in this plan.

Find a Primary Care Physician by visiting www.kp.org or call member services.

When you need chiropractic or acupuncture care, find a provider, and schedule an appointment. For participating providers visit ashlink.com/ASH/kp or call member services.

Benefits	Member Copayments		
Calendar Year Deductible	None		
Out-of-pocket Maximum	$1,500 individual; $3,000 family		
Office Visit	No charge (same for specialist)		
Preventive Services	No charge		
Diagnostic Lab and X-ray	No charge		
Advanced Imaging	No charge		
Inpatient Hospitalization	No charge		
Physician Service	No charge		
Outpatient Facility Services			
Surgery	No charge		
Urgent Care	No charge		
Emergency Room (copay waived if admitted)	$100 copay per visit		
Ambulance Services	$50 copay per trip		
Durable Medical Equipment	No charge		
Medically Necessary Acupuncture & Chiropractic Care[1] (up to 30 combines visits per year)	$10 copay per visit		
Hearing Aid Benefits	$500 allowance per device, 1 device per ear, 2 devices per 36 months		
Prescription Drug Coverage	**Pharmacy**	**Mail Order**	**Supply Limit**
Generic Drugs	$5 copay	$5 copay	Up to a 100-day
Brand Name Drugs	$5 copay	$5 copay	Up to 100-day
Specialty Drugs	$5 copay	N/A	Up to a 30-day

[1] Services authorized and provided by American Specialty Health Plans of California (ASH Plans).

Anthem Medical Premier HMO

Plan is available only in certain California counties and cities ("Service Area"). Members must access covered services through a network of physicians and facilities as directed by their Primary Care Physician. To find a Primary Care Physician visit www.anthem.com/ca/sisc or call member services.

Network: California Care HMO	Member Copayments
Calendar Year Deductible	None
Out-of-Pocket Maximum	$1,000 individual; $2,000 family
Office Visit	$10 copay per visit
MDLive[1]	No charge
Preventive Services	No charge
Diagnostic Lab and X-ray	No charge
Advanced Imaging	$100 copay
Inpatient Hospitalization (preauthorization required)	No charge
Physician Service	No charge
Outpatient Facility Services	
Surgery	No charge
Urgent Care[2]	$10 copay per visit
Emergency Room (copay waived if admitted)	$100 copay per visit
Ambulance Services	$100 copay per visit
Durable Medical Equipment	No charge
Acupuncture & Chiropractic Care (up to 30 combined visits per year)	$10 copay per visit
Hearing Aid Benefits	50% coinsurance
Prescription Drug Coverage[3]	**RX Copayments**
Out-of-Pocket Maximum:	$1,500 individual; $2,500 family
Generic Network Pharmacy Costco Pharmacy Costco Mail Order	 $5 copay $0 copay $0 copay
Brand Network Pharmacy Costco Pharmacy Costco Mail Order	 $20 copay $20 copay $50 copay
Specialty – Navitus Mail Order	$20 copay
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies

[1]Virtual access to providers and therapists.

[2]Urgent services Inside the Personal Physician's Service Area and rendered or referred by the Personal Physician or Personal Physician's Medical Group/IPA.

[3]Pharmacy Benefits are administered by Navitus Health Solutions. Navitus Specialty Rx supplies limited to no more than 30 days.

Anthem Medical 100-A PPO-Classified

Network: Prudent Buyer PPO	In Network	Out of Network[1]
Calendar Year Deductible	None	None
Out-of-pocket Maximum	$1,000 individual; $3,000 family	No limit individual; No limit family
Office Visit	$0 copay for first 3 visits then $10 copay; $10 copay for specialist	See footnote 1 (same for specialist)
MDLive[2]	No charge	Not applicable
Preventive Services	No charge	Not covered
Diagnostic Lab and X-ray	0% coinsurance	Not covered
Advanced Imaging	0% coinsurance	All billed amounts exceeding $800/test after deductible
Inpatient Hospitalization (preauthorization required)	0% coinsurance	All billed amounts exceeding $600/day after deductible
Physician Service	0% coinsurance	See footnote 1
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center Physician/surgeon fees	0% coinsurance 0% coinsurance	All billed amounts exceeding $350/day after deductible See footnote 1
Urgent Care	$10 copay per visit	See footnote 1
Emergency Room (copay waived if admitted)	$100 copay per visit + 0% coinsurance	
Ambulance Services	$100 copay + 0% coinsurance	
Durable Medical Equipment	0% coinsurance	Not covered
Acupuncture (up to 12 visits per year)	0% coinsurance	50% of maximum allowed amount
Chiropractic Care (limits apply)	0% coinsurance	Not covered
Hearing Aid Benefit[3]	0% coinsurance	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.
Prescription Drug Coverage[4]		
Out-of-Pocket Maximum:	$1,500 individual; $2,500 family	
Generic Network Pharmacy Costco Pharmacy Costco Mail Order	 $5 copay $0 copay $0 copay	
Brand Network Pharmacy Costco Pharmacy Costco Mail Order	 $10 copay $10 copay $20 copay	
Specialty – Navitus Mail Order	$10 copay	
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies	

[1]Non-participating providers can charge more than Anthem's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments, or coinsurance plus any amount that exceeds Anthem's allowable amount. Charges above the allowable amount do not count toward the calendar-year medical deductible or out-of-pocket maximum.

[2]Virtual access to providers and therapists.

[3]Up to a max combined benefits of $700 per person every 24 months for the hearing aid and ancillary equipment.

[4]Pharmacy Benefits are administered by Navitus Health Solutions.

Anthem Medical 100-A PPO-Certificated

Network: Prudent Buyer PPO	In Network	Out of Network[1]
Calendar Year Deductible	$0 individual; $0 family	
Out-of-pocket Maximum	$1,000 individual; $3,000 family	No limit individual; No limit family
Office Visit	$0 copay for first 3 visits then $10 copay; $10 copay for specialist	See footnote 1 (same for specialist)
MDLive[2]	$0 copay	Not applicable
Preventive Services	No charge	Not covered
Diagnostic Lab and X-ray	0% coinsurance	Not covered
Advanced Imaging	0% coinsurance	All billed amounts exceeding $800/test
Inpatient Hospitalization (preauthorization required)	0% coinsurance	All billed amounts exceeding $600/day
Physician Service	0% coinsurance	See footnote 1
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center Physician/surgeon fees	0% coinsurance 0% coinsurance	All billed amounts exceeding $350/day See footnote 1
Urgent Care	$10 copay per visit	See footnote 1
Emergency Room (copay waived if admitted)	$100 copay per visit + 0% coinsurance	
Ambulance Services	$100 copay + 0% coinsurance	
Durable Medical Equipment	0% coinsurance	Not covered
Acupuncture (up to 12 visits per year)	0% coinsurance	50% of maximum allowed amount
Chiropractic Care (limits apply)	0% coinsurance	Not covered
Hearing Aid Benefit[3]	0% coinsurance	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.
Prescription Drug Coverage[4]		
Out-of-Pocket Maximum:	$1,500 individual; $2,500 family	
Generic Network Pharmacy Costco Pharmacy Costco Mail Order	 $7 copay $0 copay $0 copay	
Brand Network Pharmacy Costco Pharmacy Costco Mail Order	 $25 copay $25 copay $60 copay	
Specialty – Navitus Mail Order	$25 copay	
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies	

[1]Non-participating providers can charge more than Anthem's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments, or coinsurance plus any amount that exceeds Anthem's allowable amount. Charges above the allowable amount do not count toward the calendar-year medical deductible or out-of-pocket maximum.

[2]Virtual access to providers and therapists.

[3]Up to a max combined benefits of $700 per person every 24 months for the hearing aid and ancillary equipment.

[4]Pharmacy Benefits are administered by Navitus Health Solutions.

Anthem Medical Anchor Bronze PPO

Network: Prudent Buyer PPO	In Network	Out of Network[1]
Calendar Year Deductible (all providers combined)	$5,000 individual; $10,000 family (For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)	
Out-of-pocket Maximum (includes plan deductible)	$6,350 individual; $12,700 family	No limit for both individual & family
Office Visit	30% coinsurance after deductible (same for specialist)	See footnote 1 (same for specialist)
MDLive[2]	Consult fee until deductible is met then 30% coinsurance	Not applicable
Preventive Services	No charge	Not covered
Diagnostic Lab and X-ray	30% coinsurance after deductible	Not covered
Advanced Imaging	30% coinsurance after deductible	All billed amounts exceeding $800/test after deductible
Inpatient Hospitalization (preauthorization required)	30% coinsurance after deductible	All billed amounts exceeding $600/day after deductible
Physician Service	30% coinsurance after deductible	0% coinsurance after deductible
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center	30% coinsurance after deductible	All billed amounts exceeding $350/day after deductible
Physician/surgeon fees	30% coinsurance after deductible	See footnote 1
Urgent Care	30% coinsurance after deductible	See footnote 1
Emergency Room (copay waived if admitted)	$100 copay per visit + 30% coinsurance after deductible	
Ambulance Services	$100 copay + 30% coinsurance after deductible	
Durable Medical Equipment	30% coinsurance after deductible	Not covered
Acupuncture (up to 12 visits per year)	30% coinsurance after deductible	50% of maximum allowed amount after deductible
Hearing Aid Benefit[3]	30% coinsurance after deductible	See footnote 1

Prescription Drug Coverage[4]	
Generic Network Pharmacy Costco Pharmacy Costco Mail Order	 $9 copay after deductible $0 copay after deductible $0 copay after deductible
Brand Network Pharmacy Costco Pharmacy Costco Mail Order	 $35 copay after deductible $35 copay after deductible $90 copay after deductible
Specialty – Navitus Mail Order	$35 copay after deductible
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies

[1]Non-participating providers can charge more than Anthem's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments, or coinsurance plus any amount that exceeds Anthem's allowable amount. Charges above the allowable amount do not count toward the calendar-year medical deductible or out-of-pocket maximum.

[2]Virtual access to providers and therapists.

[3]Up to a max combined benefits of $700 per person every 24 months for the hearing aid and ancillary equipment.

[4]Pharmacy Benefits are administered by Navitus Health Solutions.

Anthem Medical Minimum Value PPO

Network: Prudent Buyer PPO	In Network	Out of Network[1]
Calendar Year Deductible (all providers combined)	$5,000 individual; $10,000 family (For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)	
Out-of-pocket Maximum (includes plan deductible)	$6,350 individual; % $12,700 family	No limit for both individual & family
Office Visit	30% coinsurance after deductible (same for specialist)	See footnote 1 (same for specialist)
MDLive[2]	Consult fee until deductible is met then 30% coinsurance	Not applicable
Preventive Services	No charge	Not covered
Diagnostic Lab and X-ray	30% coinsurance after deductible	Not covered
Advanced Imaging	30% coinsurance after deductible	All billed amounts exceeding $800/test after deductible
Inpatient Hospitalization (preauthorization required)	30% coinsurance after deductible	All billed amounts exceeding $600/day after deductible
Physician Service	30% coinsurance after deductible	0% coinsurance after deductible
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center Physician/surgeon fees	30% coinsurance after deductible 30% coinsurance after deductible	All billed amounts exceeding $350/day after deductible See footnote 1
Urgent Care	30% coinsurance after deductible	See footnote 1
Emergency Room (copay waived if admitted)	$100 copay per visit + 30% coinsurance after deductible	
Ambulance Services	$100 copay + 30% coinsurance after deductible	
Durable Medical Equipment	30% coinsurance after deductible	Not covered
Acupuncture (up to 12 visits per year)	30% coinsurance after deductible	50% of maximum allowed amount after deductible
Hearing Aid Benefit[3]	30% coinsurance after deductible	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.

Prescription Drug Coverage[4]	
Generic Network Pharmacy Costco Pharmacy Costco Mail Order	 $9 copay after deductible $0 copay after deductible $0 copay after deductible
Brand Network Pharmacy Costco Pharmacy Costco Mail Order	 $35 copay after deductible $35 copay after deductible $90 copay after deductible
Specialty – Navitus Mail Order	$35 copay after deductible
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies

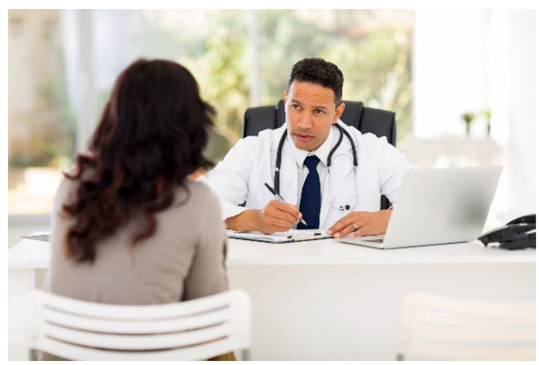
[1]Non-participating providers can charge more than Anthem's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments, or coinsurance plus any amount that exceeds Anthem's allowable amount. Charges above the allowable amount do not count toward the calendar-year medical deductible or out-of-pocket maximum.

[2]Virtual access to providers and therapists.

[3]Up to a max combined benefits of $700 per person every 24 months for the hearing aid and ancillary equipment.

[4]Pharmacy Benefits are administered by Navitus Health Solutions.

Preventive Care Screening Benefits



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **cdc.gov/prevention** for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Know Where to Go

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access
Nurse Line	Quick answers from a trained nurse	• Identifying symptoms • Decide if immediate care is needed • Home treatment options and advice	24/7
Online visit	Many non-emergency health conditions	• Cold, flu, allergies • Headache, migraine • Skin conditions, rashes • Minor injuries • Mental health concerns	24/7
Office visit	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours
Urgent care, walk-in clinic	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Office Hours, or up to 24/7
Emergency room	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or • Stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7

Employee Assistance Program (EAP)

The challenges of daily life can be stressful for various reasons. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

Pasadena City College offers EAP benefits at **no cost** to you. Please review the EAP options that are available to you and members of your household. Everything you share is confidential and stays between you and EAP*.

EAP is available 24 hours a day, seven days a week to help with:

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Work-life services
- Relationships
- Stress

Anthem EAP

Available to all District employees.

- One-on-one counseling by phone, in-person and online
- Up to 6 free counseling visits per person, per issue, per year
- LiveCONNECT instant messaging with a work-life specialist
- Legal and financial consultations
- Support on the go with the myStrength program
- Online resources

(800) 999-7222
anthemEAP.com
Company Name: SISC

Lincoln *EmployeeConnect EAP*

Available to full-time benefit eligible employees.

- One-on-one counseling by phone and in-person
- Up to 5 free counseling visits per person, per issue, per year
- Unlimited phone access to counselors
  Unlimited phone access to legal and financial experts
- Online resources
- Mobile app

(888) 628-4824
GuidanceResources.com
Username: LFGSupport
Password: LFGSupport1

Whatever life throws at you, remember that you're not alone.
When you contact EAP, you'll reach a real person dedicated to your immediate needs.

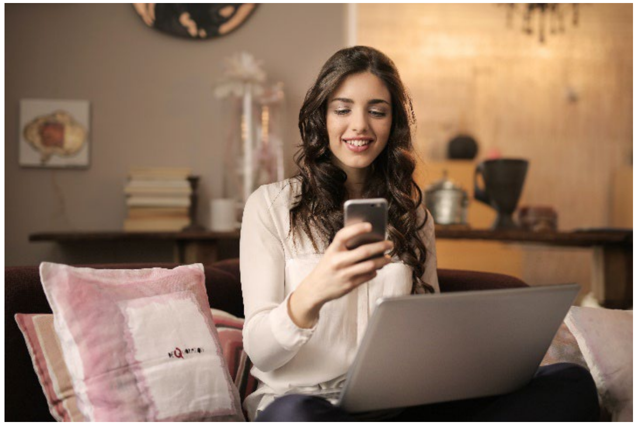
This document is for general informational purposes.
*In accordance with federal and state law, and professional ethical standards.

Self-Insured Schools of California Employee Resources

KAISER TELEHEALTH

Get quick and convenient online care from a Kaiser Permanente provider, including some prescriptions and 24/7 self-care advice — without a trip to your doctor's office. For nonurgent questions, you can simply email your doctor's office. You'll get a reply usually within 2 days, if not sooner. You can also email a pharmacist for questions about medications, or Member Services for questions about your benefits.

To access your online care options, you'll need to create a kp.org account. You can also create your online account in the Kaiser Permanente mobile app.



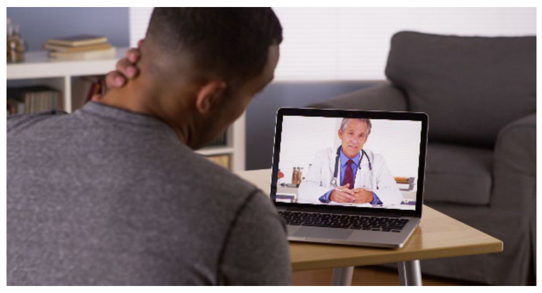
TELADOC MEDICAL EXPERTS

Use Teladoc Expert Medical Opinion when you or your eligible dependents:

- Are unsure about a diagnosis or need help choosing treatment
- Have medical questions or concerns
- Need help finding a specialist
- Have been admitted to the hospital and want expert guidance

This program is sponsored by SISC and available at no cost to all eligible employees and covered dependents. In-person visits/services will be subject to member's plan benefits.

To learn more visit www.teladoc.com/sisc.



Self-Insured Schools of California Anthem Programs

MAVEN

Maven is a value added benefit for SISC PPO members. Maven offers 24/7 virtual access to one-on-one maternity and postpartum support. Eligible SISC PPO members are matched with a Care Advocate who connects them to trustworthy maternity and postpartum content.

Free 6- month diaper subscription for SISC PPO members who:

- Enroll during their first or second trimester
- Have an intro call with a Care Advocate
- Have two appointments with Maven providers during pregnancy
- Complete the exit survey when their baby is born

Enrollment is confidential and will not be shared with your employer.

To activate your membership visit mavenclinic.com/join/sisc.

24/7 NURSELINE

Anthem members can speak directly to a registered nurse who can help you with your health-related questions. The call is free and is available to you anytime. Call the number on the back of your ID card.

MDLIVE - TELEHEALTH

Get 24/7 physician access anytime and anywhere with MDLive. Consult with doctors and pediatricians over the phone or using online video for medical conditions such as cold, fever, sore throat, flu, infection, rash, and children's health issues. Physicians can prescribe medication when appropriate. Online behavioral health visits are also available.

To register or to learn more go to www.mdlive.com/sisc.

VIDA HEALTH

Digital Health Coaching App

Get on-on-one health coaching, therapy, digital programs and other tools and resources via online or mobile access. This program helps you prevent, manage or reverse conditions such as pre-diabetes, diabetes, hypertension, obesity, depression, anxiety, etc. To learn more go to vida.com/SISC.

SYDNEY HEALTH APP

Find care near you whenever you need it. Download the Sydney Health app to find an urgent care center, retail health clinic or walk-in doctor's office quickly and get driving directions. Just search for Sydney Health at the App Store® or Google Play.™

SPECIALOFFER@ANTHEM

Anthem offers members a variety of discounts on popular programs that can help you save money and get healthier. To find discounts log in to www.anthem.com/ca/login.

ACTIVE & FIT DISCOUNT

The Active & Fit Direct program allows you to choose from participating fitness centers and studios. Plus, access to workout videos and more. To learn more go to www.anthem.com/ca/sisc (located under Value Added Benefits).

HMO COVERAGE WHEN YOU TRAVEL

When you or your covered dependents travel outside of California you can access emergency and urgent care services. To locate a provider or for additional information, please contact member services.

HMO GUEST MEMBERSHIP PROGRAM

If you or your covered dependents will be away from home for 90 consecutive days or more, you may have access to doctors and healthcare facilities in your plan where you will be staying.

To request a Guest Membership application, call member services.

Please note Guest Membership is not available in all areas and states, and benefits from the host plan may differ from benefits in the HMO plan.

PAYFORWARD

Anthem members can earn up to 15% cash back on purchases at more than 12,000 participating retailers. There's no cost to enroll. You simply enroll, shop and then earn cash back (which you can use for health care costs) or donate funds with no fees.

Visit https://anthem.payforward.com.

COSTCO GENERIC PRESCRIPTIONS

$0 co-pay for generic prescriptions. Costco membership is NOT required.

30 or 90-day supplies of most generics. Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.

To find a Costco location visit www.costco.com.

NAVITUS: SPECIALTY MEDICATIONS

Specialty medications are high-cost injectable, infused, oral, or inhaled medications that generally require special handling and may be subject to special rules such as quantity limits, prior authorization and/or step therapy. These medications have become a vital part of the treatment for chronic illnesses and complex diseases. Some medications may involve special delivery and instructions that not all pharmacies can easily provide. Navitus Specialty helps patients stay on track with treatment while offering the highest standard of compassionate care through personalized support, free delivery and refill reminders. Most medications classified as Specialty can be found on the SISC Drug List located on Navitus' secure member website Navi-Gate for Members at www.navitus.com.

CONDITION MANAGEMENT

Condition management is a confidential, voluntary program designed to help people with specific conditions stay as healthy as possible for as long as possible. Health management nurses work over the telephone with PPO plan participants who are living with one of the following conditions:

- Diabetes
- Coronary artery disease (CAD)

Please visit the Health Smarts web page at www.sischealth.com for additional information.

HINGE HEALTH

PPO members have access to Hinge Health at no cost. The program provides personalized, interactive physical therapy using the latest technology to help members conquer pain and recover from injuries. Best of all, it can be done at home.

Click on the demo video to learn how it works: Back Demo Video

Visit hingehealth.com/sisc to learn more.

VALUE-BASED SITE OF CARE BENEFIT

Hospitals and Ambulatory Surgery Centers (ASCs)

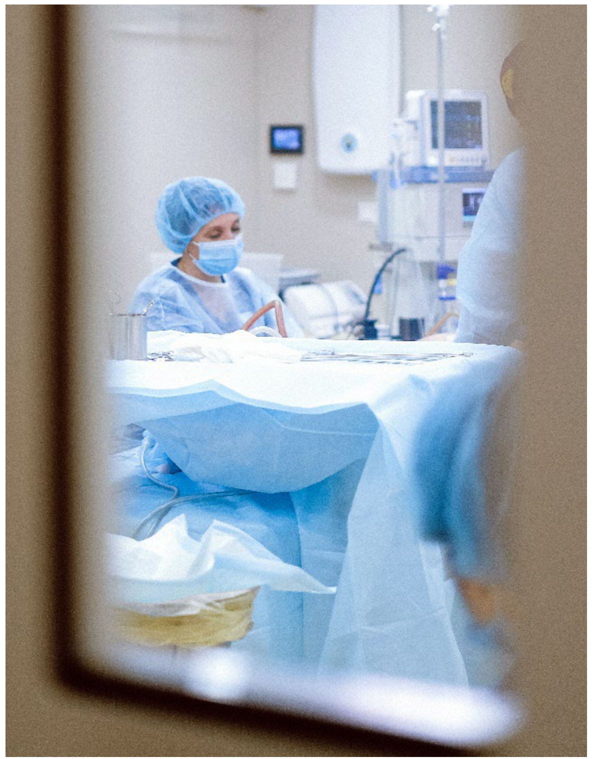
PPO plans limit the maximum benefit amount at an in-network outpatient hospital facility for the following **five** procedures:

- Arthroscopy
- Cataract Surgery
- Colonoscopy
- Upper GI Endoscopy with Biopsy
- Upper GI Endoscopy without Biopsy

NOTE: The value-based site of care benefit applies to facility fees only. The fees paid to physicians and any other practitioners who assist in the procedure, such as anesthesiologists or radiologists, are not affected.

If you use an in-network outpatient hospital facility, you will be responsible for the regular deductible and coinsurance PLUS any amount by which the hospital charge exceeds the maximum benefit. If you use an in-network ASC, you will only be responsible for the regular deductible and coinsurance.

The benefit includes an exemption process. To learn more call member services.



CARRUM HEALTH PROGRAM

PPO members can receive inpatient surgical procedures with no cost sharing (deductible applies for HSA members) at Scripps Hospital in San Diego.

Covered procedures:

- Total hip replacement
- Total knee replacement
- Cervical spinal fusion
- Lumbar spinal fusion
- Anterior/Posterior Spinal Fusion
- Discectomy/Spinal Decompression

For videos and resources, visit www.carrumhealth.com/sisc/.

ENHANCED CANCER BENEFIT

Oncology Center of Excellence Program

PPO members can consult experts who can help you navigate the complex world of cancer treatment. Services include assistance in receiving an accurate initial diagnosis and developing a comprehensive care plan. To learn more go to sisc.contigohealth.com .

Other Resources and Programs

DELTA DENTAL DIGITAL FEATURES

Toothpic, Virtual Consult, and Grin e-Magazine:

Toothpic is a photo-based teledentristry app for PPO and Premier plan members that offers virtual dental screenings from a Delta Dental dentist. Answer a few questions about your oral health, take photos of your mouth from your smartphone, and receive a personalized dental report in under 24 hours. Visit deltadental.toothpic.com to register.

Virtual Consult connects Delta Dental members and dentists for real-time video appointments. Visit deltadentalvirtualconsult.com for more information.

Virtual Consult is great if you:

- Are experiencing an urgent dental issue
- Don't have a regular dentist
- Can't take time of work or have difficulty visiting the dentist's office
- Aren't feeling well or visiting the dentist's office isn't recommended

Sign up to receive the Grin! e-magazine, which is filled with informative articles, fun facts, and tasty recipes. Go to deltadental.com/grinmag to sign up or for more information.

KAISER'S CALM APP

Calm is an app for daily use that uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality. With guided meditations, programs taught by world-renowned experts, sleep stories narrated by celebrities, mindful movement videos, and more, Calm offers something for everyone.

Visit https://kp.org/selfcareapps for more information.

TRAVELCONNECT

TravelConnect is a comprehensive program that can bring help, comfort, and reassurance if you face a medical emergency or need assistance while traveling 100 or more miles from home.

For a complete list of TravelConnect services, go to mysearchlightportal.com and enter your group ID: LFGTravel123.

DENTAL

OUR PLANS

Delta Dental PPO

MetLife DHMO

Why sign up for dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers five types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Prosthodontics** focus on dental prostheses
- **Orthodontia** treatment to properly align teeth within the mouth (not all plans include orthodontia treatments)

Dental Plans – PPO or HMO

Delta Dental Incentive PPO Plan

In this incentive plan, Delta Dental pays 70% of the PPO contract allowance for covered diagnostic, preventive and basic services and 70% of the PPO contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if employee visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

No member ID cards are distributed with this dental plan - simply provide your dentist with your name, social security number, and that you are on the Delta Dental PPO plan. To find a dentist visit deltadentalins.com/enrollees or call member services.

MetLife DHMO Plan

You and your eligible dependents must select a primary dentist from the SafeGuard DHMO directory. You can only select 2 dental offices per Benefit Plan Year. To find a dentist visit www.metlife.com/mybenefits or call member services.

	Delta PPO[1]		MetLife DHMO
	In-Network	**Out-Of-Network[2]**	**In-Network**
Calendar Year Deductible	None		None
Annual Plan Maximum	**Delta Dental PPO dentists:** $2,500 per person each calendar year **Non-Delta Dental PPO dentists:** $2,200 per person each calendar year		Not applicable
Diagnostic & Preventive Services[3]	Plan pay 70-100%		Copays vary by service; see contract for fee schedule
Basic Services[4]	Plan pays 70-100%		Copays vary by service; see contract for fee schedule
Major Services	Plan pays 70-100%		Copays vary by service; see contract for fee schedule
Orthodontic Services Orthodontic Lifetime Maximum (adults and children)	Not covered Not applicable		Up to $1,695 Copays vary by service; see contract for fee schedule

[1] You can visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees. You are responsible for any applicable deductibles, coinsurance, and amounts over plan maximums and charges for non-covered services. Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

[2] Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

[3]Bitewing x-rays are provided on request by the dentist, but no more than twice in a calendar year for children to age 18 or once for adults age 18 and over.

[4] Benefit is limited to once per tooth within a 3 year period for teeth without cavities and is for children up to and not including age 14. Refer to the plan documents for more details.

VISION

OUR PLANS

EyeMed Vision Materials Only

EyeMed Vision Full Service

Why sign up for vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

What plan option should I enroll in?

We offer two vision plans through EyeMed and your plan option is based on your Medical election:

- If you elected Anthem HMO or Kaiser HMO your vision plan option is Materials Only. ALL HMO medical plans cover eye-exams.
- If you elected an Anthem PPO plan your vision plan option is Full Service (materials & exam).

EyeMed Vision

Network providers may be accessed online at www.eyemed.com or call member services.

Network name: INSIGHT. For Out-of-Network claim form visit www.eyemed.com.

	MATERIALS ONLY		FULL SERVICE	
	In-Network Copayments	Out-Of-Network Reimbursements	In-Network Copayments	Out-Of-Network[1] Reimbursements
Examination	N/A	N/A	$0 copay	Up to $40
Frequency	N/A		1 x every 12 months	
Eyeglass Lenses (Standard)				
Single Vision	$0 copay	Up to $30	$0 copay	Up to $30
Bifocal	$0 copay	Up to $50	$0 copay	Up to $50
Trifocal	$0 copay	Up to $70	$0 copay	Up to $70
Progressive	$65-$110 copay	Up to $56	$65-$110 copay	Up to $56
Frequency	1 x every 12 months		1 x every 12 months	
Frames	$0 copay; plan pays up to $250 allowance; 20% off retail price over $250	Up to $175	$0 copay; plan pays up to $250 allowance; 20% off retail price over $250	Up to $175
Frequency	1 x every 12 months		1 x every 12 months	
Contacts[2] (conventional)				
Conventional Benefit	$0 copay; plan pays up to $180 allowance; 15% off retail price over $180	Up to $180	$0 copay; plan pays up to $180 allowance; 15% off retail price over $180	Up to $180
Medically Necessary Benefit	$0 copay, paid-in-full	Up to $210	$0 copay, paid-in-full	Up to $210
Frequency	1 x every 12 months		1 x every 12 months	

[1]If you choose to, you may receive covered benefits outside of the EyeMed network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply.

[2] In-lieu of frames.

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

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

To change your beneficiary at anytime, visit Benxcel. The username and password are your Lancerpoint (PCC) credentials.

Is your family protected?

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

Basic Life Insurance pays your beneficiary a lump sum if you die. Accidental Death and Dismemberment provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by Pasadena City College. Coverage is provided by Lincoln Financial Group.

Long Term Disability Insurance can protect you from having to tap into your retirement savings. You can use LTD benefits however you need, for housing, food medical bills, etc. Pasadena City College provides long-term disability benefits to help you recover from financial loss. Coverage is provided by Lincoln Financial Group.

Employer Paid Life[1] and Accidental Death and Dismemberment Insurance

Dependent Reminder: if you need to remove a dependent from coverage due to a qualifying event, you must notify the Benefits team within 30 days of the event.

EMPLOYEE LIFE AND AD&D

- Life amount $50,000
- AD&D amount $50,000

DEPENDENT LIFE

- Spouse or Domestic Partner $1,500 benefit amount
- Child (each)
  - From live birth but less than 6 months of age $1,500 benefit amount
  - 6 months but less than 26 years $1,500 benefit amount

[1]Life Benefit Reduction: coverage amounts begin to reduce at age 70 and benefits terminate at retirement. Spouse basic life insurance terminates when the spouse attains age 70. See the plan certificate for details.

Employer Paid Long-Term Disability[1] Insurance

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. The cost of coverage is paid in full by the District.

Monthly Benefit Amount	66.67% of monthly salary; $3,000 maximum
Benefits Begin After	140 days
Duration	See plan summary

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

Eligibility:

Class 1 - Certificated Management and Certificated employees with 5+years or more of credited CA service who have a CALSTRS Plan A retirement plan.

Class 2 - All other employees working at least 30 hours per week.

[1]Board of Trustees are not eligible for LTD benefit.

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

- **Flexible Spending Account (FSA)**
- **Voluntary Life Insurance**
- **Voluntary AD&D Insurance**
- **Pet Care Plans**

Payroll Reminder: voluntary life, AD&D and pet care plans are deducted tenthly post-tax.

You're unique—and so are your benefit needs

At Pasadena City College, there's more to your benefits than just health insurance, life insurance and retirement accounts. We also offer voluntary benefits that can help you care for your loved ones, prepare for the future and manage the unexpected.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend and reimbursements from your FSA accounts are tax-free. The catch is that you have to use the money in your account by December 31st. **You must re-enroll in this program each year. WEX (formerly Discovery Benefits) administers this program.** Click here to watch FSA 101 video.

Healthcare FSA

Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. Your spouse or tax dependent children do not have to be covered on the District's health plan. You may access your entire annual election from the first day of the plan year and you can **set aside up to $2,850 per year**.

Dependent Care FSA

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

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. **You can set aside up to $5,000** per household for eligible dependent care expenses for the year. Important: all unused Dependent Care funds will be forfeited after 12/31/22.

Access your benefits anytime, anywhere. Download the mobile app: Benefits by WEX

Important Considerations

Expenses must be incurred between 1/1/2022 and 12/31/2022.

Claims for the reimbursement of expenses incurred in any plan year shall be paid after claim has been filed. If a participant fails to submit a claim within 90 days after the end of the plan year, those expense claims will not be reimbursed. If a participant terminates employment during the plan year claims must be submitted within 90 days after termination of employment.

A participant in the Healthcare FSA can keep (roll-over) up to $570 of unused money for use in the next plan year. Unused amounts are those remaining after expenses have been reimbursed during the runout period. Runout period is 90 days. Amounts in excess of $570 will be forfeited.

There's no "crossover" spending allowed between the healthcare and dependent care accounts.

Elections cannot be changed during the plan year, unless you have a qualified change in status (and the election change must be consistent with the event).

You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (**Important:** questions about the tax status of your dependents should be addressed with your tax advisor).

Keep your receipts as proof that your expenses were eligible for IRS purposes.

Voluntary Life and Accidental Death and Dismemberment Insurance[1]

You can purchase additional life insurance and AD&D insurance to protect your family's financial security. Coverage is provided by Lincoln Financial Group.

Important:

Guarantee Issue (GI) is available at new hire enrollment/eligibility only. Any requests to increase coverage outside of this initial enrollment opportunity will be subject to medical underwriting and will require you to complete the Evidence of Insurability (EOI) form.

You can purchase life insurance and AD&D insurance for your dependent(s) if you select coverage for yourself.

Employee Voluntary Life Amount	
5X annual salary, up to $500,000 max, in increments of $10,000. Amounts over $300,000 require Evidence of Insurability (EOI).	
Employee Voluntary AD&D Amount	
5x annual salary, up to $500,000 max, in increments of $10,000.	
Spouse/Domestic Partner Voluntary Life Amount	
100% of employee coverage ($250,000 max, in increments of $5,000). Amounts over $50,000 require Evidence of Insurability (EOI).	
Spouse/Domestic Partner Voluntary AD&D Amount	
100% of employee coverage ($250,000 max, in increments of $5,000).	
Child(ren) Voluntary Life and AD&D Amounts	
• From 14 days but less than 6 months	$250
• 6 months but less than 26 years	$1,000 up to $10,000 in increments of $1,000

Evidence of Insurability (EOI): Depending on the amount of voluntary life coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health. Please email your EOI form to the Benefits Team. Insurance that requires EOI will not be effective until Lincoln approves in writing. If approved by Lincoln, coverage will become effective until the month after PCC receives the approval letter.

[1]Voluntary Life Age Range Premium adjusts take effect at Policy Anniversary (10/1). Benefit Reduction: coverage amounts begin to reduce at age 70. See the plan certificate for details.

Voluntary Pet Care Plans

At Pasadena City College, you have the freedom and flexibility to choose from a variety of voluntary benefits that meet your needs or make the most sense for you and your family, including:

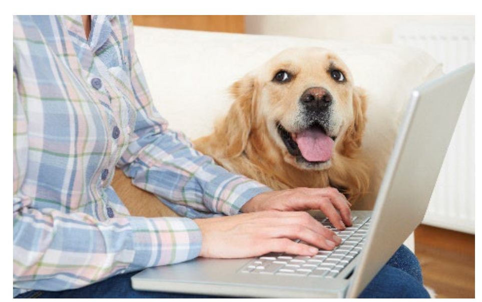
Nationwide Pet Insurance

Save with preferred pricing, use any vet anywhere, and get cash back on vet bills.

- Members are reimbursed for all covered conditions.
- Pre-existing conditions are not covered.
- Must submit a claim and vet bill for reimbursement.

To learn more visit

benefits.petinsurance.com/pasadena-area-community-college



United Pet Care

With United Pet Care, you will receive a guaranteed and instant savings on every veterinary visit. Members may visit only in-network veterinarians and ER hospitals to receive discounted services.

- Requires Primary Care Vet. Veterinary change notification required.
- You must complete the enrollment process online to receive your member ID card. Members must show ID card to receive discount.

Quick Overview Video

Program Overview Video

To learn more or to enroll visit www.unitedpetcare.com/PCC.

IMPORTANT: Policy will not be effective until Nationwide or United Pet Care approve the enrollment. Nationwide and United Pet Care determine policy effective date.

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your benefit contributions for 2022-2023
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms

Full-time Employee Cost of Coverage and Cash-In-Lieu Amount

Full-time employees must complete the Opt-Out – Refusal of Personal Coverage form, if you are not enrolled in the District's sponsored health plan and have group insurance coverage elsewhere. The form is not valid if not complete. You will need to provide a copy of current employer-sponsored group insurance card. You may fill out the form and upload the insurance card on Benxcel.

Cash-In-Lieu/Opt-Out Amounts

Pay Cycle	
12 Month	$323.50
11 Month	$352.91
10 Month	$388.20
Annually	$3,882

Employees may still enroll into dental, vision, and all other benefits offered.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify the Benefits team if your domestic partner is your tax dependent.

Variable Hour Employee Cost Of Coverage - Tenthly

Certificated

Anthem Medical PPO Anchor Bronze Plan	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	$123.77	$652.63	$776.40
EMPLOYEE + CHILD	$609.60	$609.60	$1219.20
EMPLOYEE + CHILDREN	$609.60	$609.60	$1219.20

Anthem Medical PPO Minimum Value Plan	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	$123.77	$1,111.03	$1,234.80
EMPLOYEE + ONE	$617.40	$617.40	$1,234.80
EMPLOYEE + FAMILY	$617.40	$617.40	$1,234.80

Classified

Anthem Medical PPO Anchor Bronze Plan	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	$123.77	$652.63	$776.40
EMPLOYEE + CHILD	$1,219.20	$0	$1,219.20
EMPLOYEE + CHILDREN	$1,219.20	$0	$1,219.20

Anthem Medical PPO Minimum Value Plan	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	$123.77	$1,111.03	$1,234.80
EMPLOYEE + ONE	$1,234.80	$0	$1,234.80
EMPLOYEE + FAMILY	$1,234.80	$0	$1,234.80

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify the Benefits team if your domestic partner is your tax dependent.

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

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

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

GLOSSARY

High Deductible Health Plan (HDHP)
A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

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

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis. Notices available in this booklet include:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals.
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy.
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.61% in 2022 of your modified adjusted household income.

PLAN DOCUMENTS

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Go online to Anthem or Kaiser's website to access these documents. If you would like a paper copy, please contact the Benefits team.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available by contacting the Benefits team.

- **Kaiser $0 OV HMO; Rx $5**
- **Anthem CaliforniaCare Premier 10/0 HMO; Rx 5-20**
- **Anthem 100 – A $10; Rx 5-10**
- **Anthem 100 – A $10; Rx 7-25**
- **Anthem Minimum Value PPO**
- **Anthem Anchor Bronze PPO**

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Pasadena Area Community College District Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Medicare Part D Notice

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Pasadena Area Community College District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Pasadena Area Community College District has determined that the prescription drug coverage offered by Anthem and Kaiser medical plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Pasadena Area Community College District coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Retiree Note:** If you are eligible for the District's Retiree Medical Program, when a subscriber and spouse/domestic partner are both age 65 or older and retired, and are remaining on a SISC plan, they will automatically be enrolled in Medicare Part D. Do not enroll in a Medicare Part D plan outside of SISC. This will automatically disenroll you from your SISC Medicare Part D plan.

Since the existing prescription drug coverage under Anthem and Kaiser medical plans is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Pasadena Area Community College District prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Pasadena Area Community College District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Pasadena Area Community College District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

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

Date:	October 1, 2022
Name of Entity/Sender:	Pasadena Area Community College District
Contact-Position/Office:	Benefits Office
Address:	1570 E. Colorado Blvd., C204, Pasadena, CA 91106
Phone Number:	(626) 585-7719

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Pasadena Area Community College District health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Pasadena Area Community College District health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Pasadena Area Community College District health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices Pasadena City College describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the Benefits team.

Notice of Choice of Providers

Anthem Blue Cross HMO generally 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the insurance carrier directly.

You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurance carrier directly.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance in the Summary of Benefits and Coverage (SBC) apply. If you would like more information on WHCRA benefits, call your plan's Member Services.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

Notice of Certain Deadline Extensions and Summary of Material Modifications

This document provides notice of the potential expiration of the deadline relief that began on March 1, 2020 and an explanation of how that expiration will affect certain deadlines tolled under prior guidance applicable to ERISA plans. Specifically deadlines cannot be tolled for longer than one-year, **so depending on the date an individual action would have been required, some deadline extensions will be expiring on February 28, 2021. Whether deadlines are tolled or resume will depend on the specific date you were required to take action or provide notice to the plan.** This is a Summary of Material Modifications ("Summary") to the extent those extensions applied to ERISA benefits under the Pasadena Area Community College District Health Plan ("the Plan"). You should take the time to read this Summary carefully and keep it with the Summary Plan Description ("SPD") document. If you need a copy of the SPD or if you have any questions regarding these changes to the Plan, please contact Human Resources.

End of Relief Period Extending Certain Deadlines in Response to the COVID-19 Crisis will Depend on the Date an Individual Action Would Have been Required with some Deadlines resuming Feb. 28, 2021

On April 28, 2020, Multi-Agency guidance extended certain deadlines that apply to group health plans that fall within the COVID-19 outbreak period beginning **March 1, 2020**. Those deadlines included and were limited to the following:

- The 30-day period to request special enrollment under HIPAA (or 60-day period as applicable to CHIP enrollment requests);
    - employees, spouses, and new dependents are allowed to enroll upon marriage, birth, adoption, or placement for adoption;
    - employees and dependents are allowed to enroll if they had declined coverage due to other health coverage and then lose eligibility or lose all employer contributions towards active coverage;
    - employees and their dependents are allowed to enroll upon loss of coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs;
- The 60-day election period for COBRA continuation coverage;
- The deadline for making COBRA premium payments;
- The 60-day deadline for individuals to notify a plan of a COBRA qualifying event or determination of disability;
- The deadline for individuals to file an ERISA benefit claim under the plan's claims procedure (including a H-FSA run out period deadline that ends during the outbreak period); or
- The deadline for claimants to file an appeal of an adverse benefit determination, a request for an external review, and to file information related to a request for external review for an ERISA plan.

Notice of Certain Deadline Extensions and Summary of Material Modifications

The period that these deadlines can be tolled is limited to one year. On Feb. 28, 2021, one year from March 1, 2020, some of the above timelines will no longer be tolled.

Individual timeframes listed above that are subject to deadline relief will have the applicable deadlines disregarded only until the earlier of: (a) 1 year from the date they were first eligible for relief, or (b) 60 days after the announced end of the National Emergency (the end of the Outbreak Period). On those individualized applicable dates, the timeframes for employees/participants with periods that were previously tolled will resume.

Examples and Explanations:

If a qualified beneficiary would have been required to make a COBRA election by March 1, 2020, the individual can wait until February 28, 2021, which is the earlier of 1 year from March 1, 2020 or the end of the Outbreak Period. Because the individual had 60 days to elect before the start of the Outbreak he or she would need to make an election by February 28, 2021.

If a qualified beneficiary would have been required to make a COBRA election by March 1, 2021, the Notice delays that election requirement until the earlier of 1 year from that date (March 1, 2022) or the end of the Outbreak Period, with the possibility of an additional 60-day extension.

If an individual experienced the birth of a child in February 2021 and the National Emergency was declared over July 1, 2021 **(hypothetically)**, the employee would have 60 days from the end of the National Emergency plus 30 days under HIPAA to give notice of the birth to request enrollment from the plan, September 29, 2021.

Again, if you have any questions regarding these changes to the Plan or your specific circumstances, please contact the Benefits team.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your State for more information on eligibility –

ALABAMA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child- health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance- buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecov ery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA	Medicaid

Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA Medicaid

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

IOWA Medicaid and CHIP (Hawki)

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

KANSAS Medicaid

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

KENTUCKY Medicaid

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

LOUISIANA Medicaid

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

MAINE Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740 TTY: Maine relay 711

MASSACHUSETTS Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth- premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA Medicaid

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

MISSOURI Medicaid

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

MONTANA Medicaid

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

NEBRASKA Medicaid

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

NEVADA Medicaid

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

NEW HAMPSHIRE Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

NEW YORK Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

OREGON Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

PENNSYLVANIA Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493

UTAH Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

VIRGINIA Medicaid and CHIP
Website https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924

WASHINGTON Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm Phone: 1-800-362-3002

WYOMING Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs- and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022 or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.
The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% (indexed) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or the Benefits office.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name PASADENA AREA COMMUNITY COLLEGE DISTRICT		4. Employer Identification Number (EIN) 95-250500
5. Employer address 1570 E. Colorado Blvd., C-204		6. Employer phone number (626) 585-7719 or (626) 585-7503
7. City Pasadena	8. State CA	9. ZIP code 91106
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)		12. Email address CLBAIN@pasadena.edu or czamora5@pasadena.edu

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

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

  ☐ All employees. Eligible employees are:

  ☒ Some employees. Eligible employees are:

  full-time employees, regularly working at least 30 hours per week or 130 hours per month.

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  legally married spouse, registered domestic partner and children (including domestic partner's children).

  ☐ We do not offer coverage.

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

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

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

PLAN CONTACTS

DISTRICT BENEFITS TEAM

Conna Bain
clbain@pasadena.edu
Benefits Technician
(626) 585-7719

Cristina Zamora
czamora5@pasadena.edu
Benefits and Wellness Coordinator
(626) 585-7503

Benefits Website
Benxcel Platform

Human Resources Benefits Website
pasadena.edu/hr/benefits

MEDICAL

Kaiser HMO
my.kp.org/sisc
Member Services
(800) 464-4000

Anthem HMO
www.anthem.com/ca/sisc
Member Services
(800) 825-5541

Anthem PPO
www.anthem.com/ca/sisc
Member Services
See your ID card

Anthem MDLive
www.mdlive.com/sisc
Member Services
(800) 657-6169

Teladoc
www.teladoc.com/sisc
Member Services
(808) 835-2362

PHARMACY

Navitus
Anthem Pharmacy Benefits
www.navitus.com
Member Services
(866) 333-2757

Costco
Anthem Pharmacy Benefits
www.costco.com/Pharmacy
Member Services
(800) 607-6861

DENTAL & VISION

Delta Dental PPO
www.deltadentalins.com
Member Services
(866) 499-3001

MetLife DHMO
www.metlife.com
Member Services
(800) 880-1800

EyeMed Vision
www.eyemed.com
Member Services
(866) 939-3633

EMPLOYEE ASSISTANCE PROGRAM

SISC EAP
www.anthemeap.com
Login Company Code: **SISC**
Member Services
(800) 999-7222

FLEXIBLE SPENDING ACCOUNT (FSA)

WEX Inc.
www.wexinc.com
(866) 451-3399
customerservice@wexhealth.com

ADDITIONAL BENEFITS

Nationwide
Pet Insurance
www.petinsurance.com
Member Services
(877) 738-7874

United Pet Care
Veterinary Savings Program
www.unitedpetcare.com
Member Services
(888) 781-6622