2023-2024 Benefits

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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 34-35 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

2023-2024 BENEFITS

The benefits in this guide are effective October 1, 2023 through September 30, 2024.

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 the 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 you can 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:

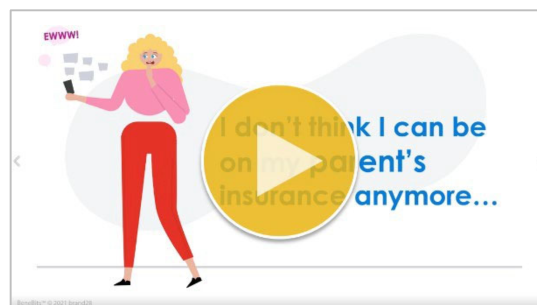
1. Any change you make must be consistent with the change in status;
2. You must notify the Benefits team within 30 days of the date the event occurs; and
3. All proper documentation is required to cover dependents (marriage certificate, birth certificate, etc.)

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.



Click to play Qualifying Life Events video

MEDICAL OVERVIEW

Our SISC Plans

Pasadena City College offers different Self-Insured Schools of California (SISC) medical plans:

Kaiser Traditional HMO

Anthem Premier HMO

Anthem 100-A PPO Classified

Anthem 100-A PPO Certificated

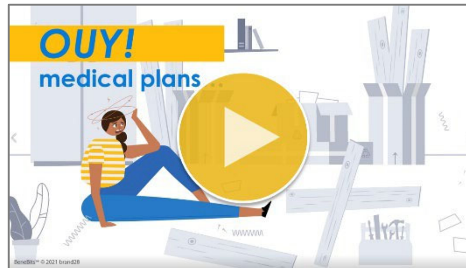
Anthem 2- Tier HSA $5000

Anthem HSA $5000

Pasadena City College pays 100% of the monthly premium, if you are a full-time employee.

HMO, PPO, Deductible… WHAT?

Not all medical plans work the same way. Watch these videos to understand how each type of plan works.



Click to play All About Medical Plans video

Kaiser Traditional Health Maintenance Organization (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. For chiropractic and acupuncture care 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	$100 copay per visit (copay waived if admitted)		
Ambulance Services	$50 copay per trip		
Durable Medical Equipment	No charge		
Medically Necessary Acupuncture & Chiropractic Care[1] - limits apply	$10 copay per visit (up to 30 combines visits per year)		
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 Premier Health Maintenance Organization (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 (same for specialist)
Virtual Healthcare - MDLive	$10 copay per visit
Preventive Services	No charge
Diagnostic Lab and X-ray	No charge
Advanced Imaging	$100 copay
Inpatient Hospitalization	No charge (preauthorization required)
Physician Service	No charge
Outpatient Facility Services	
Surgery	No charge
Urgent Care	$10 copay per visit
Emergency Room	$100 copay per visit (copay waived if admitted)
Ambulance Services	$100 copay per visit
Durable Medical Equipment	No charge
Acupuncture & Chiropractic Care – limits apply	$10 copay per visit (up to 30 combined visits per year)
Hearing Aid Benefits – limits apply	50% coinsurance
Prescription Drug Coverage[1]	**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]Pharmacy Benefits are administered by Navitus Health Solutions. Navitus Specialty Rx supplies limited to no more than 30 days.

Anthem 100-A Preferred Provider Organization (PPO) - Classified

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; same for specialist
Virtual Healthcare - MDLive	$10 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
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center Physician/surgeon fees	0% coinsurance 0% coinsurance	All billed amounts exceeding $350/day See footnote
Urgent Care	$10 copay per visit	See footnote
Emergency Room	$100 copay per visit + 0% coinsurance (copay waived if admitted)	
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 – limits apply	0% coinsurance; combined benefits of $700 per person every 24 months	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.
Prescription Drug Coverage[2]		
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]Pharmacy Benefits are administered by Navitus Health Solutions. Navitus Specialty Rx supplies limited to no more than 30 days.

Anthem 100-A Preferred Provider Organization (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; same for specialist
Virtual Healthcare - MDLive	$10 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
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center Physician/surgeon fees	0% coinsurance 0% coinsurance	All billed amounts exceeding $350/day See footnote
Urgent Care	$10 copay per visit	See footnote
Emergency Room	$100 copay per visit + 0% coinsurance (copay waived if admitted)	
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 – limits apply	0% coinsurance; combined benefits of $700 per person every 24 months	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount.
Prescription Drug Coverage[2]		
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]Pharmacy Benefits are administered by Navitus Health Solutions. Navitus Specialty Rx supplies limited to no more than 30 days.

Anthem 2- Tier Health Saving Account (HSA) $5000

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 (For individual on family coverage plan, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met.)	
Office Visit	30% coinsurance after deductible (same for specialist)	All billed amounts exceeding the maximum allowed amount[2]
Virtual Healthcare - MDLive	consult fee until deductible is met then copay	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 the maximum allowed amount[2]
Inpatient Hospitalization (preauthorization required)	30% coinsurance after deductible	See plan summary
Physician Service	30% coinsurance after deductible	All billed amounts exceeding the maximum allowed amount[2]
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center	30% coinsurance after deductible	See plan summary - $350/day max
Urgent Care	30% coinsurance after deductible	All billed amounts exceeding the maximum allowed amount[2]
Emergency Room	$100 copay per visit + 30% coinsurance after deductible (copay waived if admitted)	
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[2]
Chiropractic Care (up to 20 visits per year)	30% coinsurance after deductible	Not covered
Hearing Aid Benefit – limits apply	30% coinsurance after deductible	See plan summary
Prescription Drug Coverage[3]		
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]Review plan summary for additional details and limits. [3]Pharmacy Benefits are administered by Navitus Health Solutions.

Anthem Health Saving Account (HSA) $5000

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 (For individual on family coverage plan, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met.)	
Office Visit	30% coinsurance after deductible (same for specialist)	All billed amounts exceeding the maximum allowed amount[2]
Virtual Healthcare - MDLive	consult fee until deductible is met then copay	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 the maximum allowed amount[2]
Inpatient Hospitalization (preauthorization required)	30% coinsurance after deductible	See plan summary
Physician Service	30% coinsurance after deductible	All billed amounts exceeding the maximum allowed amount[2]
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center	30% coinsurance after deductible	See plan summary - $350/day max
Urgent Care	30% coinsurance after deductible	All billed amounts exceeding the maximum allowed amount[2]
Emergency Room	$100 copay per visit + 30% coinsurance after deductible (copay waived if admitted)	
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[2]
Chiropractic Care (up to 20 visits per year)	30% coinsurance after deductible	Not covered
Hearing Aid Benefit – limits apply	30% coinsurance after deductible	See plan summary

Prescription Drug Coverage[3]	
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]Review plan summary for additional details and limits. [3]Pharmacy Benefits are administered by Navitus Health Solutions.

Full-time employee cost of coverage and cash-in-lieu amount

Pasadena City College pays 100% of the monthly premium, if you are a full-time employee.

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	$321.50
11 Month	$350.73
10 Month	$385.80
Annually	$3,858.00

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.

Self-Insured Schools of California (SISC) Programs

24/7 Help with Personal Concerns

SISC Employee Assistance Program available to all employees.

Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.

Visit anthemEAP.com and enter SISC.

Expert Medical Opinions

Teladoc Medical Experts program available to Kaiser and Anthem members.

Get answers to health care questions and second opinions from world-leading experts.

Visit teladoc.com/SISC.

Personal Health Coaching

Vida Health program available to Anthem members except for HSA members.

Get one-on-one health coaching, therapy, chronic condition management, health trackers and other tools and resources online or via phone.

Visit vida.com/sisc.

24/7 Physician Access—Anytime, Anywhere

MDLive program available to Anthem members.

Access to virtual visits with psychiatrists and therapists for members age 10 and up. Virtual urgent care services are available to all members. Physicians can prescribe medication when appropriate.

Visit mdlive.com/sisc.

Free Generic Medications

Costco program available to Anthem members.

Access most generic medications at no cost through Costco retail and mail order pharmacies. You don't need to be a Costco member.

Visit costco.com.

Navitus Specialty Medications

Specialty medications program available to Anthem members.

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 at www.navitus.com/members.

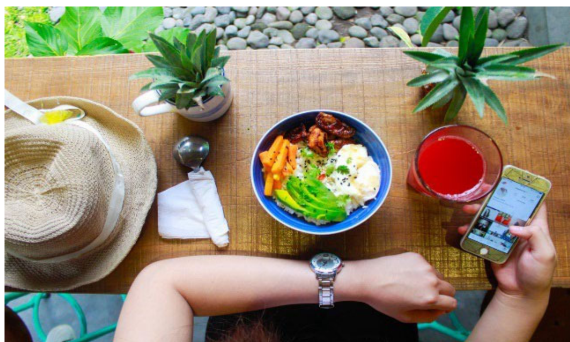
Physical Therapy for Back or Joint Pain

Hinge Health program available to Anthem members except for HSA members.

Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy.

Visit hingehealth.com/sisc.

Self-Insured Schools of California (SISC) Programs



24/7 Virtual Primary Care Doctor

Eden Health program available to Anthem PPO members.

Virtually connect with a primary care physician to manage all your physical and mental healthcare needs. Eden providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow up questions using video visits or live chat.

Visit edenhealth.com/members.

24/7 Access to Virtual Maternity and Postpartum Support

Maven program available to Anthem PPO members.

Consult with a care advocate who connects you with trustworthy content delivered by doctors, specialists' coaches and other maternity providers to help deal with pregnancy and postpartum concerns.

Visit mavenclinic.com/join/SISC.

Enhanced Cancer Benefit

Contigo Health program available to Anthem PPO members.

Consult experts on initial diagnosis and development of a care plan. Benefit includes care coordination services with at home provider, transportation, and more.

Visit contigohealth.com/sisc.

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.

Hip, Knee, and Spine Surgical Benefit

Carrum Health program available to Anthem PPO members.

Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.

Visit carrumhealth.com.

EAP is available 24 hours a day, seven days a week

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Whatever life throws at you, remember that you're not alone. 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*.

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

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

DENTAL OVERVIEW

OUR PLANS

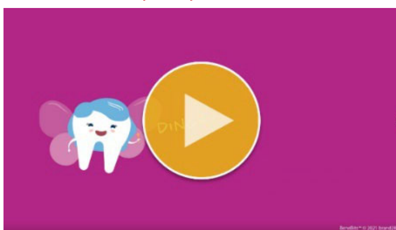
Delta Dental PPO

MetLife DHMO

To find providers visit:

- deltadentalins.com/enrollees
- www.metlife.com/mybenefits

Click to play video



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[1,3,4]		MetLife DHMO
	In-Network	Out-Of-Network[2]	In-Network
Calendar Year Deductible	None		None
Annual Plan Maximum	Delta Dental PPO dentists: $2,700 per person each calendar year Non-Delta Dental PPO dentists: $2,200 per person each calendar year		Not applicable
Diagnostic & Preventive Services Exams Cleanings X-Rays Sealants	Plan pay 70-100%		Copays vary by service; see contract for fee schedule
Basic Services Fillings, denture repair and relining Endodontics Periodontics Oral surgery	Plan pays 70-100%		Copays vary by service; see contract for fee schedule
Major Services Crowns, inlays, onlays cast restorations	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] Sealant Benefits are 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 OVERVIEW

OUR PLANS

EyeMed Vision Materials Only

- If you elected Anthem HMO or Kaiser HMO your vision plan option is Materials Only. ALL HMO medical plans cover eye-exams.

EyeMed Vision Full Service

- If you elected an Anthem PPO plan your vision plan option is Full Service (materials & exam).

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.

Network providers and member perks

Visit www.eyemed.com, select Insight network to locate providers or call member services.

Members log in to view special offers.

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

EyeMed Vision

	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.

The cost of coverage is paid in full by Pasadena City College. Coverage is provided by Lincoln Financial Group.

Disability 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]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. [2]Board of Trustees are not eligible for LTD benefit.

Employer paid Basic Life and Accidental Death and Dismemberment (AD&D) insurance[1]

Basic life insurance pays your beneficiary a lump sum if you die. AD&D insurance 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.

Employee life amount: $50,000

- AD&D benefit amount same

as basic life Spouse/Registered

Domestic Partner life amount: $1,500

Child(ren) life amount:

- 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

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.

Employer paid Long Term Disability insurance[2]

Long Term Disability (LTD) 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.

Monthly benefit amount: 66 2/3% of monthly salary; $3,000 maximum

Benefits begin after:

140 days Duration:

see plan summary

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 Accounts (FSAs)

Are you eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan (HDHP) you can only participate in a Limited Purpose FSA for dental and vision expenses, if offered. You must re-enroll in this program each year. WEX Health administers this program.

Important!

If you don't spend all the money in your healthcare FSA, you can roll over up to $610 to use the following year. 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.

There's no minimum reimbursement requirement for direct deposit; however, a $25 minimum is required for checks to be issued right away. Reimbursements that don't meet this minimum requirement will be issued after additional claims are submitted to bring the total to at least $25 or at the end of the month.

You can't change your FSA election amount mid-year unless you experience a qualifying event.

Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. Expenses must be incurred between January 1 – December 31.

How the Healthcare FSA Works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,050 (the annual limit set by the IRS). Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Dependent Care FSA—Up To $5,000 Per Year Tax-Free

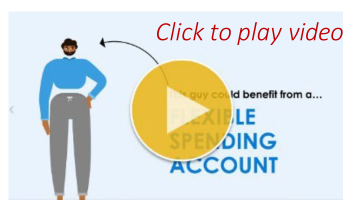
A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care.

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only child care, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

To learn more

Benefits Toolkit for eligible expenses, savings calculators, and more. Contact WEX if you have questions or need assistance.



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

Voluntary Life and Accidental Death and Dismemberment Insurance

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

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/Registered 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/Registered 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 amount:

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

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.

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.

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. The Lincoln Financial Group EOI Link is available when selecting the Voluntary Life benefit on Benxcel. You will need to create a user name and password to fill out the Evidence of Insurability form and submit via the Lincoln Portal. 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.

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.

Voluntary Pet Care Plans

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:

Resource center

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

IMPORTANT

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

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 PLAN INFORMATION

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

- Cost of coverage
- Glossary to help you understand important insurance terms
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- Plan contacts

Variable Hour Employee Cost Of Coverage - Tenthly

Certificated

Anthem Medical PPO 2-Tier HSA 5000	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	$123.93	$647.67	$771.60
EMPLOYEE + CHILD	$615.00	$615.00	$1,230.00
EMPLOYEE + CHILDREN	$615.00	$615.00	$1,230.00

Anthem Medical PPO HSA 5000	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	$ 123.93	$ 1,134.87	$1,258.80
EMPLOYEE + ONE	$ 629.40	$ 629.40	$1,258.80
EMPLOYEE + FAMILY	$ 629.40	$ 629.40	$1,258.80

Classified

Anthem Medical PPO 2-Tier HSA 5000	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	$123.93	$647.67	$771.60
EMPLOYEE + CHILD	$1,230.00	$0.00	$1,230.00
EMPLOYEE + CHILDREN	$1,230.00	$0.00	$1,230.00

Anthem Medical PPO HSA 5000	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	$123.93	$ 1,134.87	$1,258.80
EMPLOYEE + ONE	$1,258.80	$0.00	$1,258.80
EMPLOYEE + FAMILY	$1,258.80	$0.00	$1,258.80

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).

Note: Beginning January 1, 2022 the “No Surprises Act” provides protections against surprise billing for emergency services, air ambulance services, and certain services provided by a non-participating provider at a participating facility. For these services, the member’s cost are generally limited to what the charge would have been if received in-network, leaving any balance to be settled between the insurer and the out-of-network provider. Consult your health plan documents for details.

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 9.12% in 2023 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 2- Tier HSA $5000
- Anthem HSA $5000

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 the Kaiser Permanente and Anthem Blue Cross medical plans, 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 may 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 Pasadena Area Community College District is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your 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, 2023
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

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. 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 that was previously provided to you. If you need another copy of the SPD or if you have any questions regarding these changes to the Plan, please contact the Benefits team.

Notice of Expiration of Certain Deadline Relief and Summary of Material Modifications

The end of the National Emergency and Public Health Emergency will impact the expiration of many rules stemming from the COVID-19 federal emergency declarations. Information below summarizes the timing of when important rules will be phased out.

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.
- On March 18, 2020, the Families First Coronavirus Response Act (FFCRA) was signed into law and required all employer-sponsored health plans to provide coverage for testing and other services related to COVID-19 without cost sharing. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) expanded coverage of COVID-19 testing and effective January 15, 2022, Multi-Agency guidance included OTC COVID-19 tests to be covered by all group health plans without cost sharing.

This requirement was effective for the duration of the Public Health Emergency and will end May 11, 2023. 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 January 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/
Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 | State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp | Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
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/ | Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/
Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, 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

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.

[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
(800) 464-4000

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

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

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

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

PHARMACY

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

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

DENTAL & VISION

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

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

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

EMPLOYEE ASSISTANCE PROGRAM

SISC EAP
www.anthemeap.com
Login Company Code: SISC
(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
(877) 738-7874

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

Pasadena City College