



2026-2027 Benefits Full-Time Employees



Benefits that fit.

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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 41-42 for more details.



WELCOME TO YOUR BENEFITS GUIDE

2026-2027 BENEFITS

The benefits in this guide are effective October 1, 2026 through September 30, 2027.

IMPORTANT NOTE:

This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail.

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 to ensure only eligible individuals are participating in our plans. You will be required to provide documentation within 30 days of their eligibility. [Please refer to the Eligibility Documentation Chart on page 7 for required documents.](#)

[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 registered 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-registered 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 log in, 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 (First page only, financial information may be blocked out). - A marriage certificate will be accepted for newly married couples when filing has not yet been required for the current tax year.
Domestic Partner Registered for Less Than One Year	A Certificate of Registered Domestic Partnership issued by the State of California or a certified copy of the Declaration of Domestic Partnership that includes the dated, signed Secretary of State Certification Stamp. Enrolling a registered domestic partner may cause the employer contribution to become taxable.
Domestic Partner Registered for More Than One Year	- Previous year's California Tax Return showing a joint filing status --OR-- - Certificate of Registered Domestic Partnership issued by the State of California, along with a mortgage statement, rent statement, or utility bill that includes both the subscriber's and the registered domestic partner's names at the same residence address.
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
Unmarried Disabled Dependents over age 26 (dependent's disability must occur before 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 (First page only, income information may be blocked out.) - Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in 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 (First page only, income information may be blocked out.) - Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage. - Copy of Overage Dependent Certification form obtained directly from Kaiser.
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:

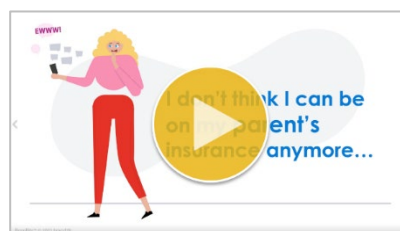
1. Any change you make must be consistent with the change in status;
2. You must notify the Benefits team within 30 days of the date the event occurs; and
3. All proper documentation is required to cover dependents (marriage certificate, birth certificate, etc.)

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.



Scan the QR code or 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 \$10 Classic PPO -
Classified

Anthem 100-A \$10 Classic PPO -
Certificated

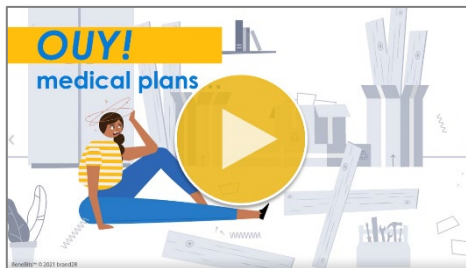
Anthem 2- Tier HSA \$5,000

Anthem HSA \$5,000

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 the video to understand how each type of plan works.



Scan the QR code or 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 to enroll in this plan. **Plan includes fertility treatment benefits.** For additional information, please refer to the plan benefit summary or other plan documents.

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		
Network Name	Kaiser Network		
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		
Most Lab and X-ray	No charge		
Inpatient Hospitalization	No charge		
Outpatient Surgery	No charge		
Urgent Care	No charge		
Emergency Room	\$100 copay per visit (copay waived if admitted)		
Ambulance	\$50 copay per trip		
Durable Medical Equipment	No charge		
Acupuncture & Chiropractic Care ¹ - limits apply	\$10 copay per visit (up to 30 combined visits per year)		
Prescription Drug Coverage	Pharmacy	Mail Order	Supply Limit
Generic Drugs	\$5 copay	\$5 copay	Up to 100-day
Brand Name Drugs	\$5 copay	\$5 copay	Up to 100-day
Specialty Drugs	\$5 copay	N/A	Up to 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"). Plan includes fertility treatment benefits. 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	You Pay	
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 or LiveHealth Online	\$0 copay per visit	
Preventive Services	No charge	
Diagnostic Lab and X-ray	No charge	
Advanced Diagnostic Imaging	\$100 copay	
Inpatient Hospitalization	No charge (preauthorization required)	
Hospital Physician Services	No charge	
Outpatient Surgery Facility Fees	No charge	
Urgent Care	\$10 copay per visit	
Emergency Room	\$100 copay per visit (copay waived if admitted)	
Ambulance	\$100 copay per trip	
Durable Medical Equipment	No charge	
Acupuncture & Chiropractic Care Rider ¹ – limits apply	\$10 copay per visit (up to 30 combined visits per year)	
Hearing Aid Benefits – limits apply	50% coinsurance	
Navitus Health Solutions Prescription Drug Coverage ²	You Pay	Supply Limit
Prescription Drug Out-of-Pocket Maximum	\$1,500 Individual / \$2,500 Family	
Generic		
Network Pharmacy	\$5 copay	30-day
Costco Pharmacy	\$0 copay	30-day or 90-day
Costco Mail Order	\$0 copay	90-day
Brand		
Network Pharmacy	\$20 copay	30-day
Costco Pharmacy	\$20 or \$50 copay	30-day or 90-day
Costco Mail Order	\$50 copay	90-day
Specialty – Navitus Mail Order	\$20 copay	30-day

¹ Services authorized and provided by American Specialty Health Plans (ASH Plans).

² Pharmacy Benefits are administered by [Navitus Health Solutions](#). Members with new maintenance medications must first fill three 30-day prescriptions before transitioning to 90-day fills. 90-day fills only available at Costco Retail or Costco Mail Order. All other network pharmacies will only do 30-day fills.

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	All billed amounts exceeding the maximum allowed amount
Virtual Healthcare – MDLive or LiveHealth Online	\$0 copay per visit	Not applicable
Preventive Services	No charge	Not covered
Diagnostic Lab and X-ray	0% coinsurance	Not covered
Advanced Diagnostic Imaging	0% coinsurance	See plan summary (coverage limited to \$800 max per test)
Inpatient Hospitalization (preauthorization required)	0% coinsurance	See plan summary (coverage limited to \$600 max per day)
Hospital Physician Service	0% coinsurance	All billed amounts exceeding the maximum allowed amount
Outpatient Surgery in an Ambulatory Surgery Center	0% coinsurance	See plan summary (coverage limited to \$350 max per day)
Urgent Care	\$10 copay per visit	All billed amounts exceeding the maximum allowed amount
Emergency Room	\$100 copay per visit + 0% coinsurance (copay waived if admitted)	
Ambulance	\$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

Navitus Health Solutions Prescription Drug Coverage ²	You Pay	Supply Limit
Prescription Drug Out-of-Pocket Maximum	\$1,500 Individual / \$2,500 Family	
Generic Network Pharmacy Costco Pharmacy Costco Mail Order	\$5 copay \$0 copay \$0 copay	30-day 30-day or 90-day 90-day
Brand Network Pharmacy Costco Pharmacy Costco Mail Order	\$10 copay \$10 or \$20 copay \$20 copay	30-day 30-day or 90-day 90-day
Specialty – Navitus Mail Order	\$10 copay	30-day

¹Non-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. Review plan summary for additional details and limits.

²Pharmacy Benefits are administered by [Navitus Health Solutions](#). Members with new maintenance medications must first fill three 30-day prescriptions before transitioning to 90-day fills. 90-day fills only available at Costco Retail or Costco Mail Order. All other network pharmacies will only do 30-day fills.

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	All billed amounts exceeding the maximum allowed amount
Virtual Healthcare – MDLive or LiveHealth Online	\$0 copay per visit	Not applicable
Preventive Services	No charge	Not covered
Diagnostic Lab and X-ray	0% coinsurance	Not covered
Advanced Diagnostic Imaging	0% coinsurance	See plan summary (coverage limited to \$800 max per test)
Inpatient Hospitalization (preauthorization required)	0% coinsurance	See plan summary (coverage limited to \$600 max per day)
Hospital Physician Service	0% coinsurance	All billed amounts exceeding the maximum allowed amount
Outpatient Surgery in an Ambulatory Surgery Center	0% coinsurance	See plan summary (coverage limited to \$350 max per day)
Urgent Care	\$10 copay per visit	All billed amounts exceeding the maximum allowed amount
Emergency Room	\$100 copay per visit + 0% coinsurance (copay waived if admitted)	
Ambulance	\$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
Navitus Health Solutions Prescription Drug Coverage ²		Supply Limit
Prescription Drug Out-of-Pocket Maximum		\$1,500 Individual / \$2,500 Family
Generic		
Network Pharmacy	\$7 copay	30-day
Costco Pharmacy	\$0 copay	30-day or 90-day
Costco Mail Order	\$0 copay	90-day
Brand		
Network Pharmacy	\$25 copay	30-day
Costco Pharmacy	\$25 or \$60 copay	30-day or 90-day
Costco Mail Order	\$60 copay	90-day
Specialty – Navitus Mail Order	\$25 copay	30-day

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Anthem 2- Tier Health Saving Account (HSA) \$5,000

Network: Prudent Buyer PPO	In-Network	Out-of-Network ¹
Calendar Year Deductible (all providers combined)	\$5,000 individual; \$10,000 family	
Out-of-Pocket Maximum (includes plan deductible)	\$6,350 individual; \$12,700 family (No one member will pay more than the per person out-of-pocket limit.)	No limit
Office Visit	30% coinsurance after deductible (same for specialist)	All billed amounts exceeding the maximum allowed amount
Virtual Healthcare – MDLive or LiveHealth Online	\$0 copay	Not applicable
Preventive Services	No charge	Not covered
Diagnostic Lab and X-ray	30% coinsurance after deductible	Not covered
Advanced Diagnostic Imaging	30% coinsurance after deductible	See plan summary (coverage limited to \$800 max per test)
Inpatient Hospitalization (preauthorization required)	30% coinsurance after deductible	See plan summary (coverage limited to \$600 max per day)
Hospital Physician Service	30% coinsurance after deductible	All billed amounts exceeding the maximum allowed amount
Outpatient Surgery in an Ambulatory Surgery Center	30% coinsurance after deductible	See plan summary (coverage limited to \$350 max per day)
Urgent Care	30% coinsurance after deductible	All billed amounts exceeding the maximum allowed amount
Emergency Room	\$100 copay per visit + 30% coinsurance after deductible (copay waived if admitted)	
Ambulance	\$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
Chiropractic Care – limits apply	30% coinsurance after deductible	Not covered
Hearing Aid Benefit – limits apply	30% coinsurance after deductible	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount

Navitus Health Solutions Prescription Drug Coverage ²	You Pay	Supply Limit
Prescription Drug Deductible	Same as medical	
Prescription Drug Out-of-Pocket Maximum	\$6,350 Individual / \$12,700 Family	
Generic Network Pharmacy Costco Pharmacy Costco Mail Order	\$9 copay after deductible \$0 copay after deductible \$0 copay after deductible	30-day 30-day or 90-day 90-day
Brand Network Pharmacy Costco Pharmacy Costco Mail Order	\$35 copay after deductible \$35 or \$90 copay after deductible \$90 copay after deductible	30-day 30-day or 90-day 90-day
Specialty – Navitus Mail Order	\$35 copay after deductible	30-day

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Anthem Health Saving Account (HSA) \$5,000

Network: Prudent Buyer PPO	In-Network	Out-of-Network ¹
Calendar Year Deductible (all providers combined)	\$5,000 individual; \$10,000 family	
Out-of-Pocket Maximum (includes plan deductible)	\$6,350 individual; \$12,700 family (No one member will pay more than the per person out-of-pocket limit.)	No limit
Office Visit	30% coinsurance after deductible (same for specialist)	All billed amounts exceeding the maximum allowed amount
Virtual Healthcare – MDLive or LiveHealth Online	\$0 copay	Not applicable
Preventive Services	No charge	Not covered
Diagnostic Lab and X-ray	30% coinsurance after deductible	Not covered
Advanced Diagnostic Imaging	30% coinsurance after deductible	See plan summary (coverage limited to \$800 max per test)
Inpatient Hospitalization (preauthorization required)	30% coinsurance after deductible	See plan summary (coverage limited to \$600 max per day)
Hospital Physician Service	30% coinsurance after deductible	All billed amounts exceeding the maximum allowed amount
Outpatient Surgery in an Ambulatory Surgery Center	30% coinsurance after deductible	See plan summary (coverage limited to \$350 max per day)
Urgent Care	30% coinsurance after deductible	All billed amounts exceeding the maximum allowed amount
Emergency Room	\$100 copay per visit + 30% coinsurance after deductible (copay waived if admitted)	
Ambulance	\$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
Chiropractic Care – limits apply	30% coinsurance after deductible	Not covered
Hearing Aid Benefit – limits apply	30% coinsurance after deductible	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount

Navitus Health Solutions Prescription Drug Coverage ²	You Pay	Supply Limit
Prescription Drug Deductible	Same as medical	
Prescription Drug Out-of-Pocket Maximum	\$6,350 Individual / \$12,700 Family	
Generic Network Pharmacy Costco Pharmacy Costco Mail Order	\$9 copay after deductible \$0 copay after deductible \$0 copay after deductible	30-day 30-day or 90-day 90-day
Brand Network Pharmacy Costco Pharmacy Costco Mail Order	\$35 copay after deductible \$35 or \$90 copay after deductible \$90 copay after deductible	30-day 30-day or 90-day 90-day
Specialty – Navitus Mail Order	\$35 copay after deductible	30-day

¹Non-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. Review plan summary for additional details and limits. ²Pharmacy Benefits are administered by [Navitus Health Solutions](#). Members with new maintenance medications must first fill three 30-day prescriptions before transitioning to 90-day fills. 90-day fills only available at Costco Retail or Costco Mail Order. All other network pharmacies will only do 30-day fills. **15**

Kaiser Resources

One Pass Select Affinity by Optum

Through One Pass Select Affinity from Optum members can choose a fitness plan and get unlimited access to all locations available within that plan, plus extensive digital resources.

Members can choose the plan that fits their needs, with competitive plans starting at \$10 per month. Members that sign up can also access the Optum Additional services include healthy meal delivery and 20% discounts on chiropractors, acupuncturists and massage therapists. Learn more at

healthy.kaiserpermanente.org/health-wellness/fitness-offerings.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (833) 574-2273.

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Visit healthy.kaiserpermanente.org/get-care/traveling to learn about what to do if you need emergency or urgent care during your trip.

Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps.

Headspace Care App

The Headspace Care app offers immediate 1-on-1 support for coping with many common challenges — from stress and low mood to issues with work and relationships, and more. Headspace Care’s highly trained emotional support coaches are ready to help 24/7, and adult Kaiser Permanente members can use Headspace Care for 90 consecutive days at no cost. Get started today at kp.org/selfcareapps.

Target Retail Clinics

Target Clinics offer care provided by Kaiser Permanente for more than 85 different services, including treatments for common health conditions and minor injuries. The clinics are open 7 days a week for appointments and walk in care. Find a clinic near you using kptargetclinic.org.

Online Wellness Tools

Visit healthy.kaiserpermanente.org/health-wellness for wellness information, health calculators, fitness videos, podcasts, and recipes from world class chefs. Connect to better health with programs to help you lose weight, quit smoking, and more — all at no cost.

Health Classes

Sign up for health classes and support groups at many of our facilities. See what’s available near you at healthy.kaiserpermanente.org/health-wellness/classes-programs— some may require a fee.

Finding a Kaiser Provider

To find a Kaiser Permanente provider near you, please visit kp.org or call (800) 464-4000.

My Health Manager

Stay engaged with your health and simplify your busy life by using the [Kaiser Website](https://healthy.kaiserpermanente.org) or download the Kaiser Permanente app from the App StoreSM or Google Play[®].



Anthem Resources

SpecialOffers

As part of your health plan, you qualify for discounts on products and services that help promote better health and well-being. These discounts are available through SpecialOffers, which can help you save money while taking care of your health. To learn more, log in to www.anthem.com/ca/mcr/sisc, choose Care, and select Discounts.

24/7 Nurse Line

24/7 NurseLine serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care. For help, call the number on the back of your ID card.

Lark Diabetes Management

Track your progress, check in with your coach, and learn more about prediabetes right in Lark's free mobile app. This program is flexible, convenient, and follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time.

Hip, Knee, and Spine Surgeries: Blue Distinction+ Requirement

In order to be covered by the Preferred Provider Organization (PPO) plan, hip and knee replacements and certain inpatient spine surgeries must be performed at an Anthem Blue Cross Blue Distinction+ center. BD+ Centers meet affordability criteria and deliver better results — including fewer complications and readmissions — than other hospitals. For a specific list of hip, knee and spine procedures that are part of the program, please call the Customer Service number on the back of your ID card. To find BD+ hospital, go to anthem.com/ca/sisc/find-care/ and scroll down to "Blue Distinction Centers and Centers of Medical Excellence".

Finding an Anthem Provider

To find a provider in the Anthem network, please visit anthem.com/ca/sisc/find-care/.

Sydney Mobile App

Use Sydney™ Health to access your plan details, Member Services, virtual care, and wellness resources. You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.



Anthem Prescription Drugs – Navitus

Anthem members have access to prescription drug coverage through Navitus. Below is some information to keep in mind regarding this coverage:

Understanding Your Pharmacy Benefits

Members who take stabilized doses of covered long-term maintenance medications — like those used to treat an ongoing condition such as high blood pressure or high cholesterol — can save money by ordering them through Navitus' mail service partner, Costco Pharmacy, instead of using a retail pharmacy.

With the Costco Home Delivery Pharmacy

- You get up to a 90-day supply delivered directly to you — with free standard shipping.
- You can easily order refills online, over the phone or by mail.
- Multiple safety and advanced quality checks are in place to make sure you get the right medication.

Please contact Costco Home Delivery Pharmacy at pharmacy.costco.com. You may also call 1-800-607-6861 for home delivery forms and instructions. Please note that some pharmacies, such as Walgreens®, may not be in your plan. Log into the member home page at navitus.com to find pharmacies that are in your plan, or call (866) 333-2757.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

Navitus Member Portal

Log in to your member portal to find answers to:

- How much your medications will cost
- Which pharmacies you can use
- Other resources available to you as part of your plan

navitus.com/who-we-serve/members



SISC Value Added Services

Take advantage of these value-added services available to SISC plan members to help you get and stay healthy.

Benefit Highlights	Availability & How To Get Started	
24/7 Help with Personal Concerns SISC Employee Assistance Program Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.	<i>All eligible employees</i> Call (800) 999-7222 Visit anthemEAP.com/SISC	
Online Counseling and Therapy Talkspace Digital platform that supports behavioral health and emotional wellness needs from a secure, HIPAA-compliant app. Up to 6 counseling sessions per situation.	<i>All eligible employees</i> Call (800) 999-7222 Visit talkspace.com/associatecare and enter SISC as your organization name	
Expert Medical Opinions Teladoc Medical Experts Get answers to health care questions and second opinions from world-leading experts. Specialists can review your diagnosis and treatment plan to help you make informed decisions.	<i>All eligible employees</i> Call (855) 380-7828 Visit teladochealth.com/SISC	
Personal Health Coaching & Therapy Vida Health Get one-on-one health coaching, therapy, chronic condition management, health trackers and other tools and resources online or via phone.	<i>Anthem members</i> Call (833) 732-2242 Visit vida.com/sisc	
24/7 Physician Access—Anytime, Anywhere MDLive 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.	<i>Anthem members</i> Call (800) 657-6169 Visit mdlive.com/sisc	
Free Generic Medications Costco¹ Get most generic prescriptions at no cost through Costco retail or mail-order pharmacies - no Costco membership required. Enjoy free home delivery from your local Costco via Instacart, with a text sent once your prescription is ready.	<i>Anthem members</i> Call (800) 774-2678 (press 1) Visit rx.costco.com	

¹ A deductible may apply for HSA members.

Members on HSA & MEC are eligible. Per IRS guidelines, in person services are subject to deductible for HSA members.

SISC Value Added Services, Cont.

Benefit Highlights

Virtual Menopause Care

Midi Health¹

Expert menopause care from home. Get personalized treatment plans, prescriptions when appropriate, and lifestyle support through virtual visits.

Availability & How To Get Started

Anthem PPO members

Visit joinmidi.com/sisc



Physical Therapy for Back or Joint Pain

Hinge Health

Conquer pain and restore mobility with personalized exercises and one-on-one guidance from a physical therapist. Plus, access to orthopedic specialists for extra support.

Anthem PPO members

Call (855) 902-2777

Visit hingehealth.com/sisc



24/7 Virtual Primary Care Doctor

Centivo Care

Skip the waiting room and get quick answers with primary care in your pocket. Use the Centivo app for same-day appointments, prescriptions, and follow-up care through secure video or live chat.

Anthem PPO members

Visit centivocare.com/sisc/ or download the app



24/7 Access to Virtual Maternity & Postpartum Support

Maven

Connect with specialists and a care advocate from pregnancy to postpartum and enjoy a free 6-month diaper subscription when you enroll before your third trimester.

Anthem PPO members

Visit mavenclinic.com/join/SISC



Hip, Knee, & Spine Surgical Benefit

Carrum Health¹

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

Anthem PPO members

Call (888) 855-7806

Visit info.carrumhealth.com/sisc



Enhanced Cancer Benefit

Lantern Cancer Care

Get help from a personal oncology nurse who can partner with you on every step of your cancer journey, including a review of your initial diagnosis and development of a care plan.

Anthem PPO members

Visit lanterncare.com



Autoimmune Support

WellTheory

Take control of your autoimmune health. Work with expert coaches to fill gaps left by medications and ease chronic symptoms like pain, fatigue, and digestive issues.

Anthem and Kaiser members

Visit welltheory.com/partner/sisc



¹ A deductible may apply for HSA members.

Members on HSA & MEC are eligible. Per IRS guidelines, in person services are subject to deductible for HSA members.

SISC PPO Value Based Site-of-Care Benefit

Hospitals and Ambulatory Surgery Centers (ASCs)

The facility fees for outpatient procedures at hospitals can be several times higher than at Ambulatory Surgery Centers (ASCs), for the same service and quality of care provided.

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

	Maximum benefit	
	In-network Outpatient Hospital Facility	In-network Ambulatory Service Center (ASC)
Arthroscopy	\$4,500	There is no maximum benefit limit at an in-network ASC.
Cataract Surgery	\$2,000	
Colonoscopy	\$1,500	
Upper GI Endoscopy with Biopsy	\$1,250	
Upper GI Endoscopy without Biopsy	\$1,000	

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.

IMPORTANT: Most physicians have privileges at both hospitals and ASCs. If you need one of the outpatient procedures on the list shown above, it will be up to you to either request treatment at the in-network ASC or have your doctor obtain an advance certification from your health plan.

Exemption Process

The benefit includes a simple process to exempt the member if the physician provides clinical justification for using a hospital. It also allows exceptions when a member lives more than 30 miles from an ASC and a hospital that offers the service for less than the maximum benefit or if a procedure cannot be scheduled in a medically appropriate timely manner due to available ASCs not having capacity.

Benefits Of Ambulatory Surgery Centers (ASCs)

1. Established track records of providing quality outcomes that are at least as good as or better than hospitals.
2. ASCs tend to be more specialized with less exposure to a wide range of infections
3. Less cumbersome check-in and check-out processes.
4. Outpatient procedures can be safely performed at an ASC more quickly for a fraction of the cost.

EAP is available 24 hours a day,
7 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 six free counseling visits per person, per issue, per year
- Get help with finding child, elder, or pet care, achieving work-life balance, retirement goals, financial or legal issues, and more
- Online resources including emotional well-being resources and mental health resources

To learn more, visit anthemEAP.com/SISC or call (800) 999-7222.

Lincoln *EmployeeConnect* EAP

Available to full-time benefit eligible employees.

- Up to three free in-person counseling sessions in six months, starting with initial contact
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue
- Get help with parenting, family, stress, grief, will preparation, and more
- Resources and support available online, via mobile app, or by phone

To learn more, visit GuidanceResources.com. New users select **Register** (web ID: LFGSupport) Follow the prompts to create your username and password. For help by phone, call (888) 628-4824.

This document is for general informational purposes. Limitations and exclusions apply.

*In accordance with federal and state law, and professional ethical standards.



DENTAL OVERVIEW

OUR PLANS

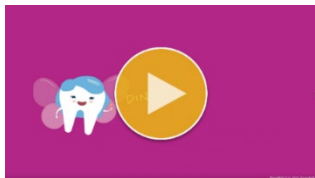
Delta Dental PPO

MetLife DHMO

To find providers visit:

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

Scan the QR code or 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 www.deltadentalins.com or call member services.

MetLife DHMO Plan

You and your eligible dependents must select a primary dentist from the **Dental HMO/Managed Care MET185** 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	\$2,700 per person each calendar year	\$2,200 per person each calendar year	Not applicable
Diagnostic & Preventive Services Exams ⁵ , Cleanings ⁵ , X-Rays	Plan pays 70-100%		Copays vary by service; see contract for fee schedule
Basic Services Fillings, Posterior Composites, Sealants, 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
Prosthodontics Implant, Bridges and Dentures	Plan pays 50%		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.

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.

⁵ Delta Dental PPO plan covers up to 4 routine cleanings and 3 oral examinations per year. MetLife HMO plan covers up to 2 routine cleanings and 2 oral examinations per year.



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 Member Cost	Out-Of-Network ¹ Reimbursements	In-Network Member Cost	Out-Of-Network ¹ Reimbursements
Examination	N/A	N/A	\$0 copay	Up to \$40
Frequency	N/A		Once every 12 months from the date of service	
Standard Lenses ²				
Single Vision	\$0 copay	Up to \$30	\$0 copay	Up to \$30
Bifocal	\$0 copay	Up to \$50	\$0 copay	Up to \$50
Trifocal/Lenticular	\$0 copay	Up to \$70	\$0 copay	Up to \$70
Progressive	\$65-\$110 copay	Up to \$56	\$65-\$110 copay	Up to \$56
Frequency	Once every 12 months from the date of service		Once every 12 months from the date of service	
Frame	\$0 copay; 20% off balance over \$250 allowance	Up to \$175	\$0 copay; 20% off balance over \$250 allowance	Up to \$175
Frequency	Once every 12 months from the date of service		Once every 12 months from the date of service	
Contact Lenses ²				
Fit and Follow-up - Standard	N/A	N/A	Up to \$40; contact lens fit and two follow-up visits	Not covered
Conventional	\$0 copay; 15% off balance over \$180 allowance	Up to \$180	\$0 copay; 15% off balance over \$180 allowance	Up to \$180
Disposable	\$0 copay; 100% of balance over \$180 allowance	Up to \$180	\$0 copay; 100% of balance over \$180 allowance	Up to \$180
Medically Necessary	\$0 copay; paid in full	Up to \$300	\$0 copay; paid in full	Up to \$300
Frequency	Once every 12 months from the date of service		Once every 12 months from the date of service	

¹If 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 Plan allows member to receive either contacts and frame, or frames and lens services.



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.

¹Life 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. ²Board of Trustees are not eligible for LTD benefit.

Employer paid Basic Life and Accidental Death and Dismemberment (AD&D) insurance¹

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 insurance²

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



VOLUNTARY PLANS

OUR VOLUNTARY PLANS

- Flexible Spending Account (FSA)
- Voluntary Life Insurance
- Voluntary AD&D Insurance
- Pet Care Plans
- American Fidelity benefits such as disability, accident, cancer, and more

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.** American Fidelity administers this program.

Important!

If you don't spend all the money in your **healthcare FSA, you can roll over up to \$680** 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 or for checks to be issued.

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.**

Click or scan to play video



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, 2026.**

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 \$3,400 (the 2026 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 \$7,500 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 childcare, 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 \$7,500 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

Go to: americanfidelity.com/info/fsa for eligible expenses, savings calculators, and more. Contact American Fidelity if you have questions or need assistance.



Access your benefits anytime, anywhere. **Download the mobile app: AFmobile**

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 username 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 Disability Insurance

Voluntary Short-Term Disability Insurance (STD)

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. You pay the cost of this coverage. Coverage is provided by American Fidelity.

Submitting a Claim

If you are disabled due to an illness or accidental injury, unable to work, and under the care of a licensed physician, you are eligible to submit a claim for benefits under this plan. As long as you remain disabled and meet the plan's disability requirements, you will continue to receive a percentage of your earnings until benefits are no longer payable.

Voluntary Long-Term Disability Insurance (LTD)

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. You pay the cost of this coverage. Coverage is provided by American Fidelity.

What to Know About LTD Insurance

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

Learn more

Go to: americanfidelity.com/info/disability for information about how disability plans work, what is covered, and more. Contact American Fidelity if you have questions or need assistance.



Voluntary Supplemental Insurance

Voluntary benefits from American Fidelity are optional coverages that help you customize your benefits package to your individual needs. You pay the entire cost for these plans through payroll deductions. For more information regarding benefit offerings and costs of coverage, schedule a one-on-one appointment with an American Fidelity representative: enroll.americanfidelity.com/D8999B36.

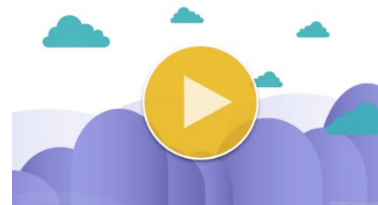
Accident Insurance

Accident Insurance helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

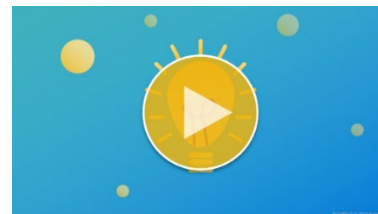
Learn more

Click or scan the video links below to learn more about these voluntary plans that are available to you:

Accident Insurance



Critical Illness



Hospital Indemnity



Cancer Insurance

Many people are concerned about the financial impact of a cancer diagnosis. Cancer insurance provides tax-free benefits for many of the costs associated with cancer treatment such as radiation, chemo, surgery, diagnostic tests, and physician charges. You can cover yourself and your family members if needed.

Critical Illness Insurance

Critical illness insurance can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

Hospital Indemnity Insurance

Hospital indemnity insurance can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide.

Voluntary Pet Care Plans

IMPORTANT

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

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 or to enroll visit:

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

[Resource center](#)

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.

To learn more or to enroll visit:

<https://portal.unitedpetcare.com/enrollment/?emp=PCC>.

[Quick Overview Video](#)

[Program Overview Video](#)





IMPORTANT PLAN INFORMATION

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

- Cost of coverage
- Cash-in-lieu
- 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

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	\$394.50
11 Month	\$430.36
10 Month	\$473.40
Annually	\$4,734.00

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

Please note that unless your registered domestic partner is your tax dependent as defined by the IRS, contributions for registered domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your registered 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 registered domestic partner is your tax dependent.

Variable Hour Employee Cost Of Coverage - Tenthly

Certificated

Anthem Medical PPO 2-Tier HSA 5000	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	\$155.88	\$790.92	\$946.80
EMPLOYEE + CHILD	\$755.40	\$755.40	\$1510.80
EMPLOYEE + CHILDREN	\$755.40	\$755.40	\$1510.80

Anthem Medical PPO HSA 5000	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	\$155.88	\$1390.92	\$1546.80
EMPLOYEE + ONE	\$773.40	\$773.40	\$1546.80
EMPLOYEE + FAMILY	\$773.40	\$773.40	\$1546.80

Classified

Anthem Medical PPO 2-Tier HSA 5000	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	\$155.88	\$790.92	\$946.80
EMPLOYEE + CHILD	\$1510.80	\$0.00	\$1510.80
EMPLOYEE + CHILDREN	\$1510.80	\$0.00	\$1510.80

Anthem Medical PPO HSA 5000	Employee Deduction	PCC Contribution	Total Premium
EMPLOYEE ONLY	\$155.88	\$1390.92	\$1546.80
EMPLOYEE + ONE	\$1546.80	\$0.00	\$1546.80
EMPLOYEE + FAMILY	\$1546.80	\$0.00	\$1546.80

Please note that unless your registered domestic partner is your tax dependent as defined by the IRS, contributions for registered domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your registered 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 registered 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 9.96% of your modified adjusted household income in 2026.

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 websites 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 can be found in the Library within [Benxcel](#). You can also request the documents from the Benefits team.

- Kaiser Traditional HMO
- Anthem Premier HMO
- Anthem 100-A \$10 Classic PPO - Classified
- Anthem 100-A \$10 Classic PPO - Certificated
- Anthem 2- Tier HSA \$5,000
- Anthem HSA \$5,000

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/registered 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](https://www.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](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

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

Date:	October 1, 2026
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 for Pasadena Area Community College District describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the Benefits team.

Notice of Choice of Providers

The Anthem Blue Cross HMO plan 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.

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, 2026**. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: myalhipp.com

Phone: (855) 692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program

Website: myakhipp.com

Phone: (866) 251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid eligibility: health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid

Website: myarhipp.com

Phone: (855) MyARHIPP (692-7447)

California – Medicaid

Health Insurance Premium Payment (HIPP) Program website:

dhcs.ca.gov/hipp

Phone: (916) 445-8322

Email: hipp@dhcs.ca.gov

Fax: (916) 440-5676

Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado website: healthfirstcolorado.com

Health First Colorado Member Contact Center: (800) 221-3943

(TTY: 711)

CHP+: hcpf.colorado.gov/child-health-plan-plus

CHP+ Customer Service: (800) 359-1991 (TTY: 711)

Health Insurance Buy-In Program (HIBI): mycohibi.com

HIBI Customer Service: (855) 692-6442

Florida – Medicaid

Website:

flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp

Phone: (877) 357-3268

Georgia – Medicaid

GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: (678) 564-1162, press 1

GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

Phone: (678) 564-1162, press 2

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: in.gov/medicaid
Website: in.gov/fssa/dfr
Family and Social Services Administration
Phone: (800) 403-0864
Member Services phone: (800) 457-4584

Iowa – Medicaid and CHIP (Hawki)

Medicaid website: hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid phone: (800) 338-8366
Hawki website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: (800) 257-8563
HIPP website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: (888) 346-9562

Kansas – Medicaid

Website: kancare.ks.gov
Phone: (800) 792-4884
HIPP Phone: (800) 967-4660

Kentucky – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website:
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: (855) 459-6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP website: kynect.ky.gov
Phone: (877) 524-4718
Medicaid website: chfs.ky.gov/agencies/dms

Louisiana – Medicaid

Louisiana Medicaid website: ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: (888) 342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP)
Website: ldh.la.gov/lahipp
LaHIPP phone: (877) 697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: (888) 716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084

Maine – Medicaid

Enrollment website: mymaineconnection.gov/benefits
Phone: (800) 442-6003 (TTY: 711)
Private Health Insurance Premium webpage:
maine.gov/dhhs/ofi/applications-forms
Phone: (800) 977-6740 (TTY: 711)

Massachusetts – Medicaid and CHIP

Website: mass.gov/masshealth/pa
Phone: (800) 862-4840 (TTY: 711)
Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: mn.gov/dhs/health-care-coverage/
Phone: (800) 657-3672

Missouri – Medicaid

Website: mydss.mo.gov/mhd/healthcare
Phone: (573) 751-2005

Montana – Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: (800) 694-3084
Email: HSHIPPProgram@mt.gov

Nebraska – Medicaid

Website: ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

Nevada – Medicaid

Medicaid website: dhcfp.nv.gov
Medicaid phone: (800) 992-0900

New Hampshire – Medicaid

Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: (603) 271-5218
Toll free number for the HIPP program: (800) 852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid and CHIP

Medicaid website:
state.nj.us/humanservices/dmahs/clients/medicaid
Phone: (800) 356-1561
CHIP Premium Assistance Phone: (609) 631-2392
CHIP website: njfamilycare.org/index.html
CHIP phone: (800) 701-0710 (TTY: 711)

New York – Medicaid

Website: health.ny.gov/health_care/medicaid
Phone: (800) 541-2831

North Carolina – Medicaid

Website: medicaid.ncdhhs.gov
Phone: (919) 855-4100

North Dakota – Medicaid

Website: hhs.nd.gov/healthcare

Phone: (866) 614-6005

Oklahoma – Medicaid and CHIP

Website: insureoklahoma.org

Phone: (888) 365-3742

Oregon – Medicaid and CHIP

Website: healthcare.oregon.gov

Phone: (800) 699-9075

Pennsylvania – Medicaid and CHIP

Website: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

Phone: (800) 692-7462

CHIP website: dhs.pa.gov/CHIP/Pages/CHIP.aspx

CHIP phone: (800) 986-KIDS (5437)

Rhode Island – Medicaid and CHIP

Website: eohhs.ri.gov

Phone: (855) 697-4347 or (401) 462-0311 (Direct Rite Share Line)

South Carolina – Medicaid

Website: scdhhs.gov

Phone: (888) 549-0820

South Dakota – Medicaid

Website: dss.sd.gov

Phone: (888) 828-0059

Texas – Medicaid

Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program

Phone: (800) 440-0493

Utah – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)

website: medicaid.utah.gov/upp

Phone: (888) 222-2542

Email: upp@utah.gov

Adult Expansion website: medicaid.utah.gov/expansion

Utah Medicaid Buyout Program website:

medicaid.utah.gov/buyout-program

CHIP website: chip.utah.gov

Vermont – Medicaid

Website: dvha.vermont.gov/members/medicaid/hipp-program

Phone: (800) 250-8427

Virginia – Medicaid and CHIP

Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select

Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP phone: (800) 432-5924

Washington – Medicaid

Website: hca.wa.gov

Phone: (800) 562-3022

West Virginia – Medicaid and CHIP

Website: dhhr.wv.gov/bms

Website: mywvhipp.com

Medicaid phone: (304) 558-1700

CHIP toll-free phone: (855) MyWVHIPP (699-8447)

Wisconsin – Medicaid and CHIP

Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm

Phone: (800) 362-3002

Wyoming – Medicaid

Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/

Phone: (800) 251-1269

To see if any other states have added a premium assistance program since **January 31, 2026**, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Benefits team.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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 (626) 585-7503 (626) 585-7006
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 cnavarro48@pasadena.edu czamora5@pasadena.edu cgonzalez31@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 registered 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

PLAN CONTACTS

Benefits Website

[Benxcel Platform](#)

Human Resources Benefits Website

pasadena.edu/hr/benefits

DISTRICT BENEFITS TEAM

Cris Navarro

cnavarro48@pasadena.edu

Benefits Technician

(626) 585-7719

Cristina Zamora

czamora5@pasadena.edu

Benefits and Wellness Coordinator

(626) 585-7503

Christian Gonzalez

cgonzalez31@pasadena.edu

Intermediate Clerk II

(626) 585-7006

MEDICAL

Kaiser HMO

www.kp.org

(800) 464-4000

Anthem HMO

www.anthem.com/ca/sisc

(800) 825-5541

Anthem PPO

www.anthem.com/ca/sisc

See your ID card

SISC Anthem MDLive

www.mdlive.com/sisc

(800) 657-6169

Teladoc

www.teladoc.com/sisc

(855) 380-7828

EMPLOYEE ASSISTANCE PROGRAM

SISC EAP

www.anthemeap.com/sisc

(800) 999-7222

PHARMACY

Navitus

Anthem Pharmacy Benefits

www.navitus.com

(866) 333-2757

Costco

Anthem Pharmacy Benefits

www.costco.com/Pharmacy

(800) 774-2678 press 1

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) 800-5457

FLEXIBLE SPENDING ACCOUNTS (FSAs)

American Fidelity

www.AmericanFidelity.com

(800) 365-9180

ADDITIONAL BENEFITS

American Fidelity

Voluntary Supplemental Plans

www.AmericanFidelity.com

(800) 365-9180

Nationwide

Pet Insurance

www.petinsurance.com

(800) 540-2016

United Pet Care

Veterinary Savings Program

www.unitedpetcare.com

(877) 872-8800