



2025-2026 Benefits Adjunct Faculty



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 22-23 for more details.



WELCOME TO YOUR BENEFITS GUIDE

2025-2026 BENEFITS

IMPORTANT NOTE:

This guide is a summary overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents including your benefit summaries, summary of benefits and coverage (SBCs) and summary plan descriptions (SPDs). The plan documents determine how all benefits are paid.

At Pasadena City College, we value your contributions to our success and want to provide you with a benefits package that protects your health.

This guide provides an overview of your healthcare coverage, cost of coverage, and more.

Offers of coverage are contingent upon your workload being at 40% full time equivalent or higher. If you are no longer eligible you will receive a COBRA notice from Benefit Coordinators Corporation (BCC). Please refer to page 6 for length of coverage.

Who's Eligible for Benefits?

Eligible dependents

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

Dependent verification

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

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

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

Adjunct Employees

You are eligible for the benefits outlined in this guide if you are an Adjunct Faculty working 40% Full Time Equivalent (FTE).

Eligibility is based on your Full Time Equivalent (FTE) working at least 40% or more every semester. If your Full Time Equivalent (FTE) load drops to under 40%, you will no longer qualify for medical, dental or vision benefits and coverage will terminate. When coverage terminates you will be eligible to elect COBRA benefits through Benefit Coordinators Corporation or you may also shop for coverage in the Marketplace, by visiting www.healthcare.gov or www.coveredca.com

If you become eligible for benefits, there is a short turnaround window for you to enroll in benefits. To see if you may qualify for benefits you may refer to Faculty Workload Value Chart on the [Adjunct Benefits Website](#).

The District will pay up to 80% of the medical insurance premium for employee-only coverage. Adjuncts who elect Kaiser HMO insurance, may purchase at their own cost, Kaiser coverage for dependents, dental insurance and/or vision insurance.

For more information regarding eligibility please visit the Adjunct Benefits Website.

Medical waiver

In lieu of the Kaiser medical plan, eligible employees may elect a composite dental and/or vision plan up to the cost of the District's medical contribution.

If you decline the Kaiser medical plan, you will be asked to fill out a waiver form and provide a card of your current medical coverage. Enrollment is not automatic.

Who is not eligible

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

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

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

Enrolling for Benefits



When you can enroll

Eligibility enrollment is an 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 eligibility date. If documentation is not received, your dependent(s) will not be enrolled.

Online Benefits Website

Coverage will be offered the month following the semester start date.

Semester	Length of Coverage
Fall	September - February
<i>Measurement Period</i> <i>Coverage Extension</i> <i>(optional coverage month)</i>	<i>March</i>
Spring	March - August
<i>Measurement Period</i> <i>Coverage Extension</i> <i>(optional coverage month)</i>	<i>September</i>

Note: Effective date may be one month after based on the date one signs up for benefits.

How to enroll or waive benefits

Email the benefits team to set up an appointment. 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.

You may review current semester benefits by scanning the QR code below.



Eligibility Documentation Chart

The following verification documents are required to enroll a dependent in health benefit plans.

IMPORTANT: Social Security Numbers for all dependents are required to be covered. PCC reserves the right to request additional documentation to substantiate eligibility.

Dependent Type	Required Documentation
Spouse	<ul style="list-style-type: none"> • Prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out). • For newly married couples where prior year tax return is not available, a marriage certificate will be accepted.
Registered Domestic Partner	<ul style="list-style-type: none"> • Certificate of Registered Domestic Partnership issued by the State of California (Enrolling a Domestic Partner may cause the employer contribution to become taxable)
Children, Stepchildren, and/or Adopted Children up to age 26	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Legal U.S. Court Documentation establishing Guardianship
Disabled Dependents over age 26	<ul style="list-style-type: none"> • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Disabled Dependent Enrollment Application • Most recent Kaiser Certification notice (if available)

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:

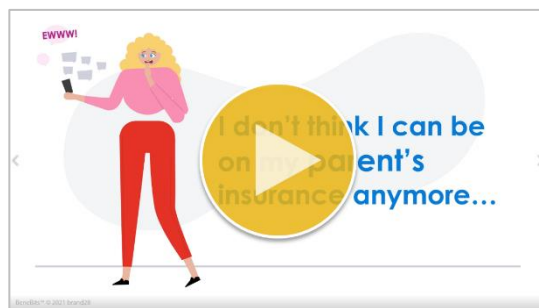
1. Any change you make must be consistent with the change in status;
2. You must notify the Benefits team within 30 days of the date the event occurs; and
3. All proper documentation is required to cover dependents (marriage certificate, birth certificate, etc.)

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

The following are considered qualifying life events:

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

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



[Click to play Qualifying Life Events video](#)





MEDICAL OVERVIEW

Our Plan

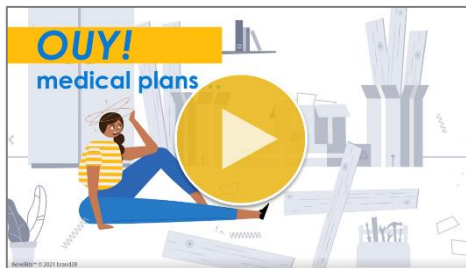
Kaiser Traditional HMO

Please note: Kaiser coverage includes an annual eye exam. If you enroll into Kaiser medical coverage, the EyeMed Materials-Only plan will be made available. If you waive Kaiser coverage you may elect the EyeMed Exam + Materials vision insurance.

Visit kp.org/ca/hmo for resources on understanding the Kaiser HMO plan.

HMO, Deductible... WHAT?

Not all medical plans work the same way. Watch the video to understand how medical plans work.



Click to play All About Medical Plans video

Kaiser Traditional HMO

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

Find a Primary Care Physician by visiting www.kp.org or call member services. For chiropractic and acupuncture care providers visit ashlink.com/ASH/kp or call member services.

Benefits	Member Copayments		
Calendar Year Deductible ¹	None		
Calendar Year Out-of-Pocket Maximum ¹	\$1,500 individual; \$3,000 family		
Office Visit	\$5 per visit (same for specialist)		
Preventive Services	No charge		
Diagnostic Lab and X-ray	No charge		
Advanced Imaging	No charge		
Inpatient Hospitalization	No charge		
Physician Service	No charge		
Outpatient Facility Services			
Surgery	\$5 per procedure		
Urgent Care	\$5 per visit		
Emergency Room	\$50 per visit (copay waived if admitted)		
Ambulance Services	\$50 copay per trip		
Durable Medical Equipment	20% coinsurance		
Hearing Aid Benefits	Not covered		
Prescription Drug Coverage	Pharmacy	Mail Order	Supply Limit
Generic Drugs	\$5 copay	\$5 copay	Up to a 100-day
Brand Name Drugs	\$5 copay	\$5 copay	Up to 100-day
Specialty Drugs	\$5 copay	N/A	Up to a 30-day

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.

RESOURCES FOR KAISER MEMBERS



FINDING A KAISER PROVIDER

To find a Kaiser Permanente provider near you, please visit www.kp.org or call (800) 464-4000. Or download the Kaiser mobile app to your device!

24/7 CARE ADVICE

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

MY HEALTH MANAGER

Stay engaged with your health and simplify your busy life by using the www.kp.org or download the Kaiser Permanente app from the App StoreSM or Google Play[®].

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Kaiser's travel website will explain what to do if you need emergency or urgent care during your trip. Go to: healthy.kaiserpermanente.org/southern-california/get-care/traveling

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.

Active&Fit

The Active&Fit Direct program allows you to choose from 9,000+ participating fitness centers and YMCAs nationwide for \$28 a month (plus a \$25 enrollment fee and applicable taxes). To enroll, visit kp.org/choosehealthy, select your area, click the "Choose Healthy" link, and click "Learn More".

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. Download the app from the App StoreSM or Google Play[®].

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.

Online wellness tools

Visit kp.org/healthyliving 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.



DENTAL OVERVIEW

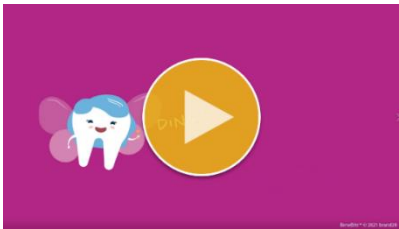
OUR PLAN

Delta Dental PPO

To find providers visit:

- deltadentalins.com/enrollees

Click or scan
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

Delta Dental PPO

Delta Dental Incentive PPO Plan

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

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

	Delta PPO ^{1,3,4}	
	In Network	Out of Network ²
Calendar Year Deductible	None	
Calendar Year Plan Maximum	Delta Dental PPO dentists: \$2,700 per person	Non-Delta Dental PPO dentists: \$2,200 per person
Diagnostic & Preventive Services Exams ⁵ , Cleanings ⁵ , X-Rays	Plan pays 70-100%	
Basic Services Fillings, Posterior Composites, Sealants, Endodontics, Periodontics, Oral surgery	Plan pays 70-100%	
Major Services Crowns, Inlays, Onlays Cast restorations	Plan pays 70-100%	
Prosthodontics Implant, Bridges and Dentures	Plan pays 50%	
Orthodontic Services Orthodontic Lifetime Maximum (adults and children)	Not covered	

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.



VISION OVERVIEW

OUR PLANS

EyeMed Vision Materials Only

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

EyeMed Vision Full Service

- If you waived the Kaiser HMO 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.

Click or scan to play video




EyeMed Vision



	MATERIALS ONLY		FULL SERVICE	
	In Network Member Cost	Out Of Network 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	\$0 copay	Up to \$70	\$0 copay	Up to \$70
Progressive Standard & Premium Tier 1-3	\$65-\$110 copay	Up to \$56	\$65-\$110 copay	Up to \$56
Progressive Premium Tier 4	\$65 copay; 20% off retail price less \$120 allowance	Up to \$56	\$65 copay; 20% off retail price less \$120 allowance	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 ² Lenses				
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 \$210	\$0 copay; paid in full	Up to \$210
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.



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**. The EAP option is available to you and members of your household. Everything you share is confidential and stays between you and EAP*.

Anthem EAP Services

- One-on-one counseling by phone, in-person and online
 - Up to 6 free counseling visits per person, per issue, per year
 - LiveCONNECT instant messaging with a work-life specialist
 - Legal and financial consultations
 - Support on the go with the myStrength program
 - Online resources
- (800) 999-7222
anthemEAP.com/SISC

This document is for general informational purposes.

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



IMPORTANT PLAN INFORMATION

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

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

Cost of Coverage – Payroll Deductions

Based on your pay schedule **deduction will be taken over 4 months, for 6 months of coverage**. All payroll benefit deductions are taken on a pre-tax basis. **Please note the rates below are monthly rates not annual rates.**

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.

Kaiser Medical HMO	Total Cost	PCC Contribution	Employee Payroll Deduction
EMPLOYEE ONLY	\$1,871.67	\$1,497.33	\$374.34
EMPLOYEE + SPOUSE	\$4,117.68	\$1,497.33	\$2,620.35
EMPLOYEE + CHILD(REN)	\$3,369.02	\$1,497.33	\$1,871.69
FAMILY	\$5,802.18	\$1,497.33	\$4,304.85
ACSIG Delta Dental PPO	Total Cost	PCC Contribution	Employee Payroll Deduction
EMPLOYEE ONLY <u>OR</u> EMPLOYEE + DEPENDENTS	\$205.50	\$0.00	\$205.50
EyeMed Materials Only	Total Cost	PCC Contribution	Employee Payroll Deduction
EMPLOYEE ONLY <u>OR</u> EMPLOYEE + DEPENDENTS	\$18.80	\$0.00	\$18.80

Medical waiver

If the medical plan is waived, **the District will pay 100% of the premium for dental and vision plans: ACSIG Delta Dental PPO and EyeMed Exam + Materials**. To enroll in the dental and vision plans you must schedule an appointment with a benefits team member.

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.

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.

-E-

Eligibility Enrollment

The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Eligibility enrollment is held one time each year. Outside of eligibility 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.

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).

GLOSSARY

-H-

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.

-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-

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.

-T-

Telehealth/Telemedicine

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 8.39% in 2024 of your modified adjusted household income.

PLAN DOCUMENTS

SUMMARY PLAN DESCRIPTIONS (SPD)

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

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

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

- Kaiser Traditional HMO

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 medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your 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.

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, 2025
Name of Entity/Sender:	Pasadena Area Community College District
Contact-Position/Office:	Benefits Office
Address:	1570 E. Colorado Blvd., C204, Pasadena, CA 91106
Phone Number:	(626) 585-7719

HIPAA Notice of Special Enrollment Rights

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

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

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

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

Availability of Privacy Practices Notice

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

Notice of Choice of Providers

HMO plans generally require 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 July 31, 2025. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid

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

Phone: 678-564-1162, press 1

GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra> | Phone: 678-564-1162, press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program All other Medicaid Website: <https://www.in.gov/medicaid/> | <http://www.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: [Iowa Medicaid | Health & Human Services](#) | Medicaid Phone: 1-800-338-8366

Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](#) | Hawki Phone: 1-800-257-8563

HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](#)

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/> | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)

Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx> | Phone: 1-855-459-6328

Email: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kynect.ky.gov> | Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003 | TTY: Maine relay 711

Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa> | Phone: 1-800-862-4840 | TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/> | Phone: 1-800-657-3672

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084 | email: HHSHIPPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/> | Phone: 800-356-1561

CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare Phone: 1-866-614-6005
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, 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



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.¹²

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 the 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 1 570 E. Colorado Blvd., C-204		6. Employer phone number (626) 585-7719 or (626) 585-7503	
7. City Pasadena	8. State CA	9. ZIP code 91106	
10. Who can we contact about employee health coverage at this job? Human Resources			
11. Phone number (if different from above)		12. Email address CLBAIN@pasadena.edu or czamora5@pasadena.edu	

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

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

All employees. Eligible employees are:

☐☒

Some employees. Eligible employees are:

full-time employees, regularly working at least 30 hours per week or 130 hours per month. Adjunct Faculty working 40% Full Time Equivalent (FTE) or more every semester.

- With respect to dependents:

☒

We do offer coverage. Eligible dependents are:

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

☐

We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](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

DISTRICT BENEFITS TEAM

Conna Bain

clbain@pasadena.edu

Benefits Technician

(626) 585-7719

Cristina Zamora

czamora5@pasadena.edu

Benefits and Wellness Coordinator

(626) 585-7503

Christian Gonzalez

cgonzalez31@pasadena.edu

Intermediate Clerk II

(626) 585-7006

DISTRICT BENEFITS ONLINE RESOURCES

Benefits Website

[Benxcel Platform](#)

**Human Resources Adjunct Benefits
Website**

pasadena.edu/hr/benefits/adjunctbenefits.php

CARRIER CONTACTS

MEDICAL

Kaiser HMO

kp.org

(800) 464-4000

kp.org/getcare

kp.org/ca/hmo

[Kaiser health & wellness](#)

[Kaiser PCC Adjuncts Microsite](#)

DENTAL & VISION

Delta Dental PPO

www.deltadentalins.com

(866) 499-3001

EyeMed Vision

www.eyemed.com

(866) 723-0513

EMPLOYEE ASSISTANCE PROGRAM

SISC EAP

www.anthemep.com/sisc

(800) 999-7222