



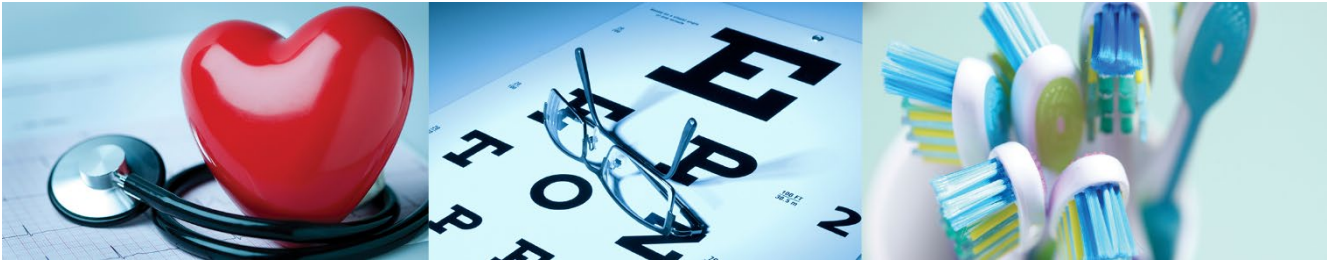
2020-21 BENEFITS OVERVIEW

10/01/2020 –
09/30/2021

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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 federal law gives you more choices about your prescription drug coverage. Please see Annual Notice on pages 32-33 for more details.



District Message

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. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

We are providing you with this booklet to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts and resources are provided on the back cover page of this booklet.

While we've made every effort to make sure that this booklet is comprehensive, it cannot provide a complete description of all benefit provisions. For more information, please contact the Benefits Office. The information in this booklet is a general outline of the benefits offered under the Pasadena City College benefits program. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC) and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this booklet differs from the plan documents, the plan documents will prevail.

**The benefits in this summary are effective:
October 1, 2020 – September 30, 2021**

IMPORTANT EMPLOYEE RESPONSIBILITIES

Review your benefit options.

Visit the **Benxcel Platform** and enroll or waive insurance benefits.

See page 5 for login instructions.

Employees waiving medical must provide proof of enrollment in another employer-sponsored group medical plan.

If you have questions, contact the Benefits Team:

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

Cristina Zamora - czamora5@pasadena.edu or (626) 585-7503

Eligibility



WHO IS ELIGIBLE?

All active, eligible full-time employees are eligible for the benefits outlined in this booklet.

You can enroll the following family members in our plans:

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- If you have a registered domestic partnership with the California Secretary of State, your domestic partner is eligible for coverage. Please contact Benefits if you would like to add a registered domestic partner. Any premiums for your domestic partner paid for by Pasadena City College are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children (including your domestic partner's children):
 - o Up to the age of 26 are eligible to enroll in medical, dental, vision, and basic life coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
 - o Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
 - o Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

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 proof of one or more of the following within 30 days of their eligibility:

- Marriage certificate or license (if married less than a year)
- Most recent Federal income tax return
- Certificate of registered domestic partnership issued by the State of California.
- Birth certificate
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of the disabling condition (for dependent children over age 26 incapable of self-support)

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

WHO IS NOT ELIGIBLE?

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

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

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

Eligibility Continued

WHEN CAN I 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 the change. If the life event is due to a divorce, a divorce decree is required. If the domestic partnership is being nullified, a copy of the Notice of Termination of Domestic Partnership is required.

Changes must be submitted to Benefits 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.

QUALIFYING LIFE EVENTS

The following are considered qualifying life events:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, and death of a spouse
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child
- Change in employment status that affects benefits eligibility, including the start or

termination of employment by you, your spouse, or your dependent child

- Change in work schedule, including a switch between part-time and full-time employment that affects eligibility for benefits
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- Change in place of residence or worksite, including a change that affects the accessibility for network providers
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child
- An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA) including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act. Under provisions of the Act, employees have 60 days after the following events to request enrollment:
 - Employee or dependent loses eligibility for Medicaid
 - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP

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

- i. Any change you make must be consistent with the change in status;
- ii. You must make the change within 30 days of the date the event occurs; and
- iii. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.)

How to Enroll or Waive Benefits

Go online to our Benefits website: [Benxcel Platform](#). The username and password are your Lancerpoint (PCC) credentials. After you login, you'll 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 Benefits:

- clbain@pasadena.edu or (626) 585-7719
- czamora5@pasadena.edu or (626) 585-7503

DEPENDENT 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	<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.
Domestic Partner	<ul style="list-style-type: none"> • Certificate of Registered Domestic Partnership issued by the State of California (AB 205 Compliant) • SISC Affidavit of Domestic Partnership (when applicable)
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 Court Documentation establishing Guardianship
Disabled Dependents over age 26	<p>Anthem Blue Cross (All items listed below are required)</p> <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 Anthem Disabled Dependent Certification Form <p>Kaiser (All items listed below are required)</p> <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)

Cost of Coverage and Cash-In-Lieu Amount

Pasadena City College pays 100% of Medical, Dental, and Vision benefits for all full-time employees and their eligible dependents.

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](#).

FULL-TIME EMPLOYEE CASH-IN-LIEU/OPT-OUT AMOUNTS

PAY CYCLE	
12 Month	\$ 305.50
11 Month	\$ 333.27
10 Month	\$ 366.60
Annually	\$ 3,666.00

CERTIFICATED VARIABLE HOUR EMPLOYEES – TENTHLY PAY CYCLE

ANTHEM MEDICAL PPO ANCHOR BRONZE PLAN	EMPLOYEE DEDUCTION	PCC CONTRIBUTION	TOTAL PREMIUM
Employee Only	\$122.15	\$611.05	\$733.20
Employee + Child	\$575.40	\$575.40	\$1,150.80
Employee + Children	\$575.40	\$575.40	\$1,150.80

ANTHEM MEDICAL PPO MINIMUM VALUE PLAN	EMPLOYEE DEDUCTION	PCC CONTRIBUTION	TOTAL PREMIUM
Employee Only	\$122.15	\$1,043.05	\$1,165.20
Employee + One	\$582.60	\$582.60	\$1,165.20
Employee + Family	\$582.60	\$582.60	\$1,165.20

CLASSIFIED VARIABLE HOUR EMPLOYEES – TENTHLY PAY CYCLE

ANTHEM MEDICAL PPO ANCHOR BRONZE PLAN	EMPLOYEE DEDUCTION	PCC CONTRIBUTION	TOTAL PREMIUM
Employee Only	\$122.15	\$611.05	\$733.20
Employee + Child	\$1,150.80	\$0.00	\$1,150.80
Employee + Children	\$1,150.80	\$0.00	\$1,150.80

ANTHEM MEDICAL PPO MINIMUM VALUE PLAN	EMPLOYEE DEDUCTION	PCC CONTRIBUTION	TOTAL PREMIUM
Employee Only	\$122.15	\$1,043.05	\$1,165.20
Employee + One	\$1,165.20	\$0.00	\$1,165.20
Employee + Family	\$1,165.20	\$0.00	\$1,165.20

Kaiser Medical Traditional HMO

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

Find a Primary Care Physician by visiting my.kp.org/sisc or call member services (800) 464-4000.

When you need chiropractic or acupuncture care, find a provider, and schedule an appointment. For participating providers visit ashlink.com/ASH/kp or call (800) 678-9133.

	Copayments		
Calendar Year Deductible	None		
Annual Out-of-Pocket Max	\$1,500 individual \$1,500 per member/\$3,000 family		
Physician Office Visit	No charge		
Specialist Office Visit	No charge		
Preventive Services	No charge		
Outpatient Diagnostic X-ray and Lab	No charge		
Advanced Diagnostic Imaging (MRI/PET/CAT scans)	No charge		
Inpatient Hospitalization	No charge		
Physician Services	No charge		
Outpatient Facility Services			
Surgery	No charge		
Urgent Care	No charge		
Emergency Room (copay waived if admitted)	\$100 copay per visit		
Ambulance Services	\$50 copay per trip		
Durable Medical Equipment	No charge		
Medically Necessary Acupuncture & Chiropractic Care ¹ (up to 30 combined visits per year)	\$10 copay per visit		
Hearing Aid Benefit	\$500 allowance per device, 1 device per ear, 2 devices per 36 months		
Prescription Drugs	Pharmacy	Mail Order	Supply Limit
Generic	\$5 copay	\$5 copay	Up to a 100-day
Brand	\$5 copay	\$5 copay	Up to a 100-day
Specialty	\$5 copay	N/A	Up to a 30-day

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

Anthem Medical Premier HMO

Plan is available only in certain California counties and cities ("Service Area"). Members must access covered services through a network of physicians and facilities as directed by their Primary Care Physician. To find a Primary Care Physician visit <https://www.anthem.com/ca/sisc/> or call member services (800) 825-5541.

Network: California Care HMO	Copayments
Calendar Year Deductible	None
Medical Out-of-Pocket Maximum	\$1,000 individual; \$2,000 family
Physician/Specialist Office Visit	\$10 copay per visit
MDLive ¹ Consultation	\$5 copay per visit
Preventive Services	No charge
Diagnostic X-ray and Lab	No charge
Advanced Imaging: CT, CAT, MRI, PET, etc.	\$100 copay per test
Inpatient Hospitalization (preauthorization required)	No charge
Physician Services	No charge
Outpatient Facility Services	
Surgery in an Ambulatory Surgery Center	No charge
Surgery in a Hospital	No charge
Urgent Care ² (office setting)	\$10 copay per visit
Emergency Room (copay waived if admitted)	\$100 copay per visit
Ambulance Services (ground or air)	\$100 copay per visit
Durable Medical Equipment	No charge
Acupuncture & Chiropractic Care	\$10 copay per visit
Hearing Aid Benefits	50% coinsurance
Prescription Drugs³	
Out-of-Pocket Maximum	\$1,500 individual/\$2,500 family
Generic	
Network Pharmacy	\$5 copay
Costco Pharmacy	\$0 copay
Costco Mail Order	\$0 copay
Brand	
Network Pharmacy	\$20 copay after deductible
Costco Pharmacy	\$20 copay after deductible
Costco Mail Order	\$50 copay after deductible
Specialty – Navitus Mail Order	\$20 copay after deductible
Supply Limit	Members may receive up to 30 days and/or up-to 90 days supply of medication at participating pharmacies.

¹ 24/7 virtual access to providers and therapists.

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

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

Anthem Medical 100-A PPO - Classified

Network: Prudent Buyer PPO	In-Network	Out-of-Network ¹
Calendar Year Deductible	\$0 individual; \$0 family	
Medical Out-of-Pocket Max	\$1,000 individual; \$3,000 family	No limit individual; No limit family
Professional Services		
Physician Office Visit	\$0 copay for the first three visits then \$10 copay	See footnote 1
Specialist Office Visit	\$10 copay per visit	See footnote 1
MDLive ² Consultation	\$5 copay per visit	Not applicable
Preventive Services	No charge	Not covered
Diagnostic X-ray and Lab	0% coinsurance after deductible	Not covered
Advanced Imaging: CT, CAT, MRI, PET, etc.	0% coinsurance after deductible	All billed amounts exceeding \$800/test after deductible
Inpatient Hospitalization (preauthorization required)	0% coinsurance after deductible	All billed amounts exceeding \$600/day after deductible
Physician Services	0% coinsurance after deductible	See footnote 1
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center	0% coinsurance after deductible	All billed amounts exceeding \$350/day after deductible
Physician/surgeon fees	0% coinsurance after deductible	See footnote 1
Urgent Care	\$10 copay per visit	See footnote 1
Emergency Room (copay waived if admitted)	\$100 copay per visit + 0% coinsurance after deductible	
Ambulance Services (ground or air)	\$100 copay + 0% coinsurance after deductible	
Durable Medical Equipment	0% coinsurance after deductible	Not covered
Acupuncture (up to 12 visits per year)	0% coinsurance after deductible	50% of maximum allowed amount after deductible
Chiropractic Care	0% coinsurance after deductible	Not covered
Hearing Aid Benefit ³	0% coinsurance after deductible	Not covered
Prescription Drugs⁴		
Out-of-Pocket Maximum	\$1,500 individual/\$2,500 family	
Generic		
Network Pharmacy	\$5 copay	
Costco Pharmacy	\$0 copay	
Costco Mail Order	\$0 copay	
Brand		
Network Pharmacy	\$10 copay after deductible	
Costco Pharmacy	\$10 copay after deductible	
Costco Mail Order	\$20 copay after deductible	
Specialty – Navitus Mail Order	\$10 copay after deductible	
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies.	

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

² 24/7 virtual access to providers and therapists.

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

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

Anthem Medical 100-A PPO – Certificated

Network: Prudent Buyer PPO	In-Network	Out-of-Network ¹
Calendar Year Deductible	\$0 individual; \$0 family	
Medical Out-of-Pocket Max	\$1,000 individual; \$3,000 family	No limit individual; No limit family
Professional Services		
Physician Office Visit	\$0 copay for the first three visits then \$10 copay	See footnote 1
Specialist Office Visit	\$10 copay per visit	See footnote 1
MDLive ² Consultation	\$5 copay per visit	Not applicable
Preventive Services	No charge	Not covered
Diagnostic X-ray and Lab	0% coinsurance after deductible	Not covered
Advanced Imaging: CT, CAT, MRI, PET, etc.	0% coinsurance after deductible	All billed amounts exceeding \$800/test after deductible
Inpatient Hospitalization (preauthorization required)	0% coinsurance after deductible	All billed amounts exceeding \$600/day after deductible
Physician Services	0% coinsurance after deductible	See footnote 1
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center	0% coinsurance after deductible	All billed amounts exceeding \$350/day after deductible
Physician/surgeon fees	0% coinsurance after deductible	See footnote 1
Urgent Care	\$10 copay per visit	See footnote 1
Emergency Room (copay waived if admitted)	\$100 copay per visit + 0% coinsurance after deductible	
Ambulance Services (ground or air)	\$100 copay + 0% coinsurance after deductible	
Durable Medical Equipment	0% coinsurance after deductible	Not covered
Acupuncture (up to 12 visits per year)	0% coinsurance after deductible	50% of maximum allowed amount after deductible
Chiropractic Care	0% coinsurance after deductible	Not covered
Hearing Aid Benefit ³	0% coinsurance after deductible	Not covered
Prescription Drugs⁴		
Out-of-Pocket Maximum	\$1,500 individual/\$2,500 family	
Generic		
Network Pharmacy	\$7 copay	
Costco Pharmacy	\$0 copay	
Costco Mail Order	\$0 copay	
Brand		
Network Pharmacy	\$25 copay after deductible	
Costco Pharmacy	\$25 copay after deductible	
Costco Mail Order	\$60 copay after deductible	
Specialty – Navitus Mail Order	\$25 copay after deductible	
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies.	

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

² 24/7 virtual access to providers and therapists.

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

⁴ Pharmacy Benefits are administered by **Navitus Health Solutions**.

Anthem Medical Anchor Bronze PPO

Network: Prudent Buyer PPO	In-Network	Out-of-Network ¹
Calendar Year Deductible (all providers combined)	\$5,000 individual; \$10,000 family (For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)	
Medical Out-of-Pocket Max (includes plan deductible)	\$6,350 individual; \$12,700 family	No limit individual; No limit family
Professional Services		
Physician/Specialist Office Visit	30% coinsurance after deductible	See footnote 1
MDLive ² Consultation	Consult fee until deductible is met then 30% coinsurance	Not applicable
Preventive Services	No charge	Not covered
Diagnostic X-ray and Lab	30% coinsurance after deductible	Not covered
Advanced Imaging: CT, CAT, MRI, PET, etc.	30% coinsurance after deductible	All billed amounts exceeding \$800/test after deductible
Inpatient Hospitalization (preauthorization required)	30% coinsurance after deductible	All billed amounts exceeding \$600/day after deductible
Physician Services	30% coinsurance after deductible	0% coinsurance after deductible
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center	30% coinsurance after deductible	All billed amounts exceeding \$350/admit after deductible
Physician/surgeon fees	30% coinsurance after deductible	See footnote 1
Urgent Care	30% coinsurance after deductible	See footnote 1
Emergency Room (copay waived if admitted)	\$100 copay per visit + 30% coinsurance after deductible	
Ambulance Services (ground or air)	\$100 copay + 30% coinsurance after deductible	
Durable Medical Equipment	30% coinsurance after deductible	Not covered
Acupuncture (up to 12 visits per year)	30% coinsurance after deductible	50% of maximum allowed amount after deductible
Chiropractic Care	30% coinsurance after deductible	Not covered
Hearing Aid Benefit ³	30% coinsurance after deductible	See footnote 1
Prescription Drugs⁴		
Generic		
Network Pharmacy	\$9 copay after deductible	
Costco Pharmacy	\$0 copay after deductible	
Costco Mail Order	\$0 copay after deductible	
Brand		
Network Pharmacy	\$35 copay after deductible	
Costco Pharmacy	\$35 copay after deductible	
Costco Mail Order	\$90 copay after deductible	
Specialty – Navitus Mail Order	\$35 copay after deductible	
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies.	

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

² 24/7 virtual access to providers and therapists.

³ Up to a max combined benefit of \$700 per pair every 24 months for the hearing aid and ancillary equipment.

⁴ Pharmacy Benefits are administered by **Navitus Health Solutions**.

Anthem Medical Minimum Value PPO

Network: Prudent Buyer PPO	In-Network	Out-of-Network ¹
Calendar Year Deductible (all providers combined)	\$5,000 individual; \$10,000 family (For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)	
Medical Out-of-Pocket Max (includes plan deductible)	\$6,350 individual; \$12,700 family	No limit individual; No limit family
Professional Services		
Physician/Specialist Office Visit	30% coinsurance after deductible	See footnote 1
MDLive ² Consultation	Consult fee until deductible is met then 30% coinsurance	Not applicable
Preventive Services	No charge	Not covered
Diagnostic X-ray and Lab	30% coinsurance after deductible	Not covered
Advanced Imaging: CT, CAT, MRI, PET, etc.	30% coinsurance after deductible	All billed amounts exceeding \$800/test after deductible
Inpatient Hospitalization (preauthorization required)	30% coinsurance after deductible	All billed amounts exceeding \$600/day after deductible
Physician Services	30% coinsurance after deductible	0% coinsurance after deductible
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center	30% coinsurance after deductible	All billed amounts exceeding \$350/admit after deductible
Physician/surgeon fees	30% coinsurance after deductible	See footnote 1
Urgent Care	30% coinsurance after deductible	See footnote 1
Emergency Room (copay waived if admitted)	\$100 copay per visit + 30% coinsurance after deductible	
Ambulance Services (ground or air)	\$100 copay + 30% coinsurance after deductible	
Durable Medical Equipment	30% coinsurance after deductible	Not covered
Acupuncture (up to 12 visits per year)	30% coinsurance after deductible	50% of maximum allowed amount after deductible
Chiropractic Care	30% coinsurance after deductible	Not covered
Hearing Aid Benefit ³	30% coinsurance after deductible	See footnote 1
Prescription Drugs⁴		
Generic		
Network Pharmacy	\$9 copay after deductible	
Costco Pharmacy	\$0 copay after deductible	
Costco Mail Order	\$0 copay after deductible	
Brand		
Network Pharmacy	\$35 copay after deductible	
Costco Pharmacy	\$35 copay after deductible	
Costco Mail Order	\$90 copay after deductible	
Specialty – Navitus Mail Order	\$35 copay after deductible	
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies.	

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

² 24/7 virtual access to providers and therapists.

³ Up to a max combined benefit of \$700 per pair every 24 months for the hearing aid and ancillary equipment.

⁴ Pharmacy Benefits are administered by **Navitus Health Solutions**.

Dental Plans – PPO or HMO

Delta Dental Incentive PPO Plan

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

No member ID cards are distributed with this dental plan - simply provide your dentist with your name, social security number, and that you are on the Delta Dental PPO plan. To find a dentist visit deltadentalins.com/enrollees or call (800) 765-6003.

MetLife DHMO Plan

You and your eligible dependents must select a primary dentist from the [SafeGuard DHMO](#) directory. You can only select 2 dental offices per Benefit Plan Year. To find a dentist visit www.metlife.com/mybenefits or call (800) 880-1800.

	Delta PPO ¹		MetLife DHMO
	In-Network	Out-Of-Network ²	In-Network
Calendar Year Deductible	None		None
Annual Plan Maximum	In-network dentists: \$2,500 per person each calendar year Out-of-Network dentists: \$2,200 per person each calendar year		Not applicable
Diagnostic & Preventive Services Exams Cleanings X-Rays	Plan pays 70-100%		Copays vary by service; see contract for fee schedule
Basic Services Fillings, Posterior Composites & Sealants Endodontics Oral surgery	Plan pays 70-100%		Copays vary by service; see contract for fee schedule
Periodontics	Plan pays 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 Bridges and dentures	50%		Copays vary by service; see contract for fee schedule
Orthodontic Services	Not covered		Adults and Children
Orthodontic Lifetime Maximum	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.

EyeMed Vision

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

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

Network providers may be accessed online at www.eyemed.com or call 866-723-0596.

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

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

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

² In-lieu of frames.

Flexible Spending Account



A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. And reimbursements from your FSA accounts are tax-free. The catch is that you have to use the money in your account by December 31, 2021. **You must re-enroll in this program each year.** Discovery Benefits administers this program. [Click here to watch Discovery Benefits FSA 101 video.](#)

HEALTHCARE FSA

Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents.

Your spouse or tax dependent children do not have to be covered on the Districts health plan.

You may access your entire annual election from the first day of the plan year and you can set aside **up to \$2,750 per year.**

[Click here to search eligible expenses.](#)

DEPENDENT CARE FSA

Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

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

DISCOVERY BENEFITS

P: (866) 451-3399

E: customerservice@discoverybenefits.com

W: www.discoverybenefits.com

IMPORTANT CONSIDERATIONS

Expenses must be incurred between 1/1/2021 and 12/31/2021.

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

A participant in the Health FSA can keep (roll-over) up to \$550 of unused money for use in the next plan year. Unused amounts are those remaining after expenses have been reimbursed during the runout period. Runout period is 90 days. Amounts in excess of \$550 will be forfeited.

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

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

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

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

Access your benefits anytime, anywhere. Download the mobile app: **Benefits By Discovery Benefits.**

Life Insurance¹ and Long-Term Disability

EMPLOYER PAID LIFE AND AD&D

Basic Life insurance pays your beneficiary a lump sum if you die. Accidental Death & Dismemberment (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. **The District also provides dependent life insurance and the cost of coverage is paid in full by the District.**

Life Amount	\$50,000
AD&D Amount	\$50,000

DEPENDENT LIFE

- Spouse or Domestic Partner \$1,500 benefit amount
- Child (each) \$1,500 benefit amount

EMPLOYER PAID LONG-TERM DISABILITY²

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

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.

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

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

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver. **Dependent Reminder:** if you need to remove a dependent from coverage due to a qualifying

event, you must notify the Benefits Office within 30 days of the event.

VOLUNTARY LIFE³ AND VOLUNTARY AD&D

Voluntary Life and Voluntary AD&D insurance plans allow you to purchase additional coverage to protect your family's financial security. Insurance coverage is provided by Lincoln Financial Group.

NOTE: 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.

Employee Voluntary Life Amount

5X annual salary, up to \$500,000 max, in increments of \$10,000. Amounts over \$300,000 require Evidence of Insurability (EOI).

Employee Voluntary AD&D Amount

5x annual salary, up to \$500,000 max, in increments of \$10,000.

Spouse/Domestic Partner Voluntary Life Amount

100% of employee coverage (\$250,000 max, in increments of \$5,000). Amounts over \$50,000 require Evidence of Insurability (EOI).

Spouse/Domestic Partner Voluntary AD&D Amount

100% of employee coverage (\$250,000 max, in increments of \$5,000).

Child(ren) Voluntary Life and AD&D Amounts

- From 14 days but less than 6 months of age \$250
- 6 months but less than 26 years \$1,000 up to \$10,000 in increments of \$1,000

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

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

² Board of Trustees are not eligible for LTD benefit.

³ **Voluntary Life Age Range Premium adjusts** take effect at Policy Anniversary (10/1).

Pet Care Voluntary Benefits

When your pet gets sick, bills can add up faster than expected. Here are some valuable pet care plans that you are eligible to participate in:

NATIONWIDE PET INSURANCE

Between big-ticket emergency vet bills and basic preventive care, My Pet Protection coverage helps pet parents get back 90% of the vet bill for covered services/conditions.

MY PET PROTECTION OVERVIEW

- Members may visit any veterinarian, at anytime, anywhere in the world.
- All pets are eligible and must live in the same household.
- Members are reimbursed for all covered conditions. Pre-existing conditions are not covered.
- \$7,500 maximum annual benefit and \$250 annual deductible per pet plan.
- Wellness is a buy-up option that includes spay/neuter, vaccinations and more.
- Must submit a claim and vet bill for reimbursement.
- Submit claims from your smartphone with the free VitusVet app.
- May take up to 30 days to receive reimbursement.
- Members have free, 24/7 access to VetHelpline.
- Tenthly post-tax benefit deduction.



UNITED PET CARE

With United Pet Care, you will receive a guaranteed and instant savings of 20-50% off every veterinary visit.

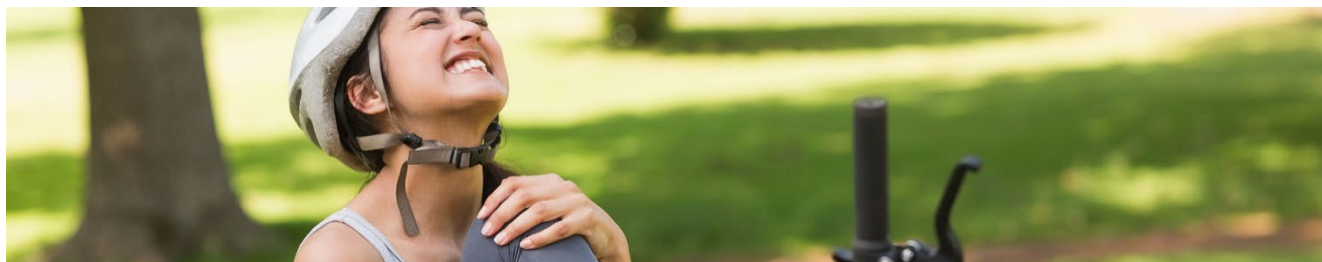
PET SAVINGS PROGRAM OVERVIEW

- Members may visit only in-network veterinarians and ER hospitals to receive discounted services.
- Requires Primary Care Vet. Veterinary change notification required.
- All pets are eligible and do not have to live in the same household.
- No annual benefit limit or deductible.
- Members must show ID card to receive discount. Savings applied instantly in vet's office.
- Wellness is included in pricing.
- Tenthly post-tax benefit deduction.








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

Getting Care When You Need It Now



The Emergency Room (ER) is not your only option! With many options for getting care, how do you choose? This chart can help you understand your options.

Where to go	What is it	What can be treated
Virtual Care 	E-visits, telephone, and video visits are simple and secure ways to get care and save yourself an office visit.	<ul style="list-style-type: none"> • Cough, cold and flu • Sore throat • Eye conditions • Rash • Sinus problems • Urinary tract infection • Mental Health • And more...
Nurse Line 	Speak directly to a registered nurse, 24/7 day or night who can help you with your health-related questions.	<ul style="list-style-type: none"> • Choosing appropriate medical care • Finding a doctor or hospital • Understanding treatment options • Achieving a healthier lifestyle • Answering medication questions
Your Doctor's Office 	Go to a doctor's office when you need preventive or routine care. Your doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	<ul style="list-style-type: none"> • Annual Physical • Checkups • Preventive services • Minor skin conditions • Vaccinations • General health management
Urgent Care (UC) 	Urgent care is ideal for when you need care quickly, but it is not an emergency (and your doctor isn't available). Urgent care centers treat issues that aren't life-threatening.	<ul style="list-style-type: none"> • Sprains • Strains • Minor burns • Minor infections • Minor broken bones • Cuts that may need a few stitches
Emergency Room (ER) 	The ER is for serious life-threatening or very serious conditions that require immediate care. This is also when to call 911.	<ul style="list-style-type: none"> • Breathing difficulty • Chest pain • Heavy bleeding • Major broken bones • Major burns • Severe head injury • Spinal injuries • Sudden weakness or trouble talking

Self-Insured Schools of California Employee Resources

EMPLOYEE ASSISTANCE PROGRAM

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through Anthem can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Anthem EAP is available to all full-time and part-time employees of Pasadena City College.

If you need counseling, you get up to 6 visits with a licensed professional and best of all, it's free.

Help is available 24/7, 365 days a year by telephone at (800) 999-7222.

Other resources are available online at www.anthemEAP.com; Company Code **SISC**.

The program is available to your family and household members.

LIFEKEYS – ADDITIONAL EAP

LifeKeys services include:

- Online will preparation
- Information on important life matters
- Protection against identity theft
- Guidance and support for your beneficiaries

It's easy to access LifeKeys services. Just call (855) 891-3684 or visit GuidanceResources.com. To register use **LifeKeys** for Organization Web ID.

TRAVELCONNECT

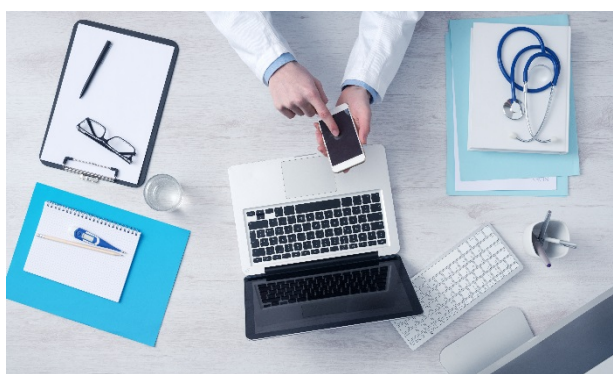
TravelConnect is a comprehensive program that can bring help, comfort, and reassurance if you face a medical emergency or need assistance while traveling 100 or more miles from home.

For a complete list of TravelConnect services, go to mysearchlightportal.com and enter your group ID: LFGTravel123. To use TravelConnect services, call On Call International at (866) 525-1955.

EXPERT MEDICAL OPINIONS

Program provides medical second opinions from nationally recognized experts specializing in specific areas of need, with no required travel. This service can also assist members with locating top, in-network doctors for in-person visits¹. This program is sponsored by SISC and available at no cost to eligible employees and covered dependents.

Getting started with Expert Medical Opinions program is completely confidential and only takes a few minutes.



To begin using this benefit, members must register online at www.advance-medical.net/sisc/ or call Advance Medical at (855) 201-9925.

KAISER TELEHEALTH

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

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

¹ In-person visits/services will be subject to member's plan benefits.

Self-Insured Schools of California Anthem Programs

COSTCO GENERIC PRESCRIPTIONS

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

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

Costco mail order: pharmacy.costco.com

(800) 607-6861



NAVITUS: SPECIALTY MEDICATIONS

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

MDLIVE - TELEHEALTH

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

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

24/7 NURSELINE

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

SYDNEY HEALTH APP

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

VIDA HEALTH

Digital Health Coaching App

Get one-on-one health coaching, therapy, digital programs and other tools and resources via online or mobile access. This program helps you prevent, manage or reverse conditions such as pre-diabetes, diabetes, hypertension, obesity, depression, anxiety, etc. To learn more go to vida.com/SISC or call (855) 442-5885.

Self-Insured Schools of California Anthem Programs

CONDITION MANAGEMENT

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

- Diabetes
- Coronary artery disease (CAD)

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

DIABETES PREVENTION PROGRAM

Did you know that one in three people are at risk of developing type 2 diabetes? With the Diabetes Prevention Program, you can learn more about wellness, make changes to start losing weight and reduce your risk of developing type 2 diabetes.

Programs you can select may include:

- Weight Watchers
- Healthslate®
- Jenny Craig
- Noom®
- RetrofitSM
- Skinny Gene Project
- And more

Start the journey to a healthier you with a one-minute quiz. Visit www.solera4me.com/SISC.

ENHANCED CANCER BENEFIT Oncology Center of Excellence Program

PPO members can consult experts who can help you navigate the complex world of cancer treatment. Services include assistance in receiving an accurate initial diagnosis and developing a comprehensive care plan. It covers care coordination services with a home provider, transportation benefits and more. To learn more go to sisc.hdplus.com or call (877) 220-3556.

AUTISM SPECTRUM DISORDERS PROGRAM

This program helps families touched by ASD. Families with children who fall somewhere on the Autism Spectrum can get the support they need through this program. To learn more call (844) 269-0538.

HINGE HEALTH

PPO members have access to Hinge Health at no cost to you. The program provides personalized, interactive physical therapy using the latest technology to help members conquer back, knee, or hip pain without drugs or surgery. Best of all, it can be done at home.

Eligible members receive wearable sensors and a monitoring device to guide you through virtual therapy sessions. You also receive unlimited access to a personal health coach, exercises, and educational articles on your condition and treatment options.

Click on the demo video to learn how it works: [Back Demo Video](#)

Visit hingehealth.com/sisc to learn more or call (855) 902-2777.

CARRUM HEALTH PROGRAM

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

Covered procedures:

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

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

Self-Insured Schools of California Anthem Programs

VALUE-BASED SITE OF CARE BENEFIT

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

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

How it works:

- If you use a participating ambulatory surgery center or a participating outpatient hospital that provides these surgeries within your maximum benefit, you won't have extra costs beyond your deductible and coinsurance.
- If you use any outpatient hospital or nonparticipating ambulatory surgery center that charges above your maximum benefit, you'll have to pay the difference in cost, in addition to your deductible and coinsurance.

To learn more visit <https://www.anthem.com/ca/sisc/> or call member services.

SPECIALOFFERS@ANTHEM

Anthem offers members a variety of discounts on popular programs that can help you save money and get healthier. Login to Anthem's website to find discounts on:

- Vision and hearing
- Family and home
- Medicine and treatment

ACTIVE & FIT GYM DISCOUNT

The Active & Fit Direct program allows you to choose from 9,000+ participating fitness centers and YMCAs nationwide for \$25 a month (plus a \$25 enrollment fee and applicable taxes).

To enroll, visit SpecialOffers by logging in to www.anthem.com/ca/sisc and clicking on Discounts.

PAYFORWARD — earn up to 15% back at your favorite stores

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

HMO CARE AWAY FROM HOME

Through the Blue Cross Blue Shield Global Core program, **HMO members** can access emergency and urgent care services across the country and around the world. While you can receive urgent care services from any provider, using the Global Core program can be more cost-effective and less hassle. You may not need to pay for the services upfront, but if you do, you will be able to submit a claim for reimbursement. You can locate a provider any time by calling (800) 810-BLUE or by going to the Find a Doctor section of anthem.com/ca/sisc.

Through the Care Away From Home program you can apply for **Guest Membership**, if you will be temporarily outside of your service area for at least 90 days in one location. To request a Guest Membership application, call (800) 827-6422.

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

Key Terms

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

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.

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.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

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. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred 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.

Important Plan Notices and Documents

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

HIPAA Notice of Special Enrollment Rights

Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.

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.

Notice of Choice of Providers

Notifies you about the plan's requirement that you name a Primary Care Physician (PCP).

Exchange Notice

Provides basic information about the Marketplace and employment-based health coverage offered by your employer.

Medicare Part D Notice

Describes options to access prescription drug coverage for Medicare eligible individuals.

COBRA Continuation Coverage Notice

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

Summary of Benefits and Coverage (SBC)

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The following SBCs are available by contacting Benefits:

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

Summary Plan Description (SPD)

A Summary Plan Description, or SPD, is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

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

Statement of Material Modifications

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

Required Federal Notices

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

The Federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that we periodically remind you of your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting the insurance carriers directly.

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.

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. For deductibles and coinsurance review the plan's benefit summary. 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's Member Services.

Availability of Summary Information

As an employee, the health benefits provided by Pasadena City College represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Pasadena City College offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by Pasadena City College are available by contacting the Benefits Office.

Notice of Choice of Providers

Anthem Blue Cross HMO plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. 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.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information

In 2014 a new way to buy health insurance took effect: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace runs from November to December. Coverage begins January 1st. For other essential enrollment information visit <https://www.healthcare.gov/quick-guide>.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan.

However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.78%¹ of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit².

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources Department.

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.

¹ ACA Shared-Responsibility Affordability Percentage for plan year 2020 is 9.78%.

² An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

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

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

- As your employer, we offer a health plan to:
 - ☐ All employees. Eligible employees are
 - ☒ Some employees. Eligible employees are: full-time employees, regularly working at least an average of 30 hours per week or 130 hours per month.
- With respect to dependents:
 - ☒ We do offer coverage. Eligible dependents are: legally married spouse, registered domestic partner and children (including domestic partner's children).
 - ☐ We do not offer coverage.
 - ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under Pasadena Area Community College District's group plan.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from online.

You may have other options available to you when you lose group health coverage

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- 1) Your spouse dies;
- 2) Your spouse's hours of employment are reduced;
- 3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- 4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- 5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- 1) The parent-employee dies;
- 2) The parent-employee's hours of employment are reduced;
- 3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- 4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- 5) The parents become divorced or legally separated; or
- 6) The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

There may be other coverage options for you and your family. When key parts of the health care law took effect, you are able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify your district.

Your dependent child may be eligible for continued coverage under your policy during the period of time he/she:

- 1) Is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and,
- 2) Is chiefly dependent upon you for support and maintenance

If your dependent will meet both of these criteria at the time he/she reaches the dependent maximum age, please submit documentation demonstrating compliance with both criteria within 60 days. If you do not submit adequate documentation within the appropriate time, your disabled child will not be covered under your policy after he/she reaches the dependent maximum age.

The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

Other Coverage Options Available besides COBRA Continuation Coverage

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

For More Information

If you have questions about your COBRA continuation coverage, you should contact the Benefits Office. For more information about your rights under the Employment Retirement Income Security Act (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S.

Department of Labor's Employee Benefits Security Administration (EBSA) in your area, visit the website at www.dol.gov/ebsa or call their toll-free number at (866) 444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

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

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 Kaiser and Anthem are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
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When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Pasadena Area Community College District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Pasadena Area Community College District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 1, 2020
Name of Entity/Sender:	Pasadena Area Community College District
Contact-Position/Office:	Benefits Office
Address:	1570 E. Colorado Blvd., C204, Pasadena, CA 91106
Phone Number:	(626) 585-7719

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

For Benefits Assistance

Provider	Plan	Phone Number	Website
Kaiser	Medical	(800) 464-4000	my.kp.org/sisc
Anthem	Medical HMO	(800) 825-5541	www.anthem.com/ca/sisc
Anthem	Medical PPO	See your ID card.	www.anthem.com/ca/sisc
Anthem	Medical - MDLive	(800) 657-6169	www.mdlive.com/sisc
Advance Medical	Expert Second Opinion Program	(855) 201-9925	advance-medical.net/sisc
Navitus	Anthem Pharmacy Benefits	(866) 333-2757	https://www.navitus.com
Costco	Anthem Pharmacy Benefits	(800) 607-6861	www.costco.com/Pharmacy
Delta Dental	Dental PPO	(866) 499-3001	www.deltadentalins.com
MetLife	Dental HMO	(800) 880-1800	www.metlife.com
EyeMed	Vision	(866) 939-3633	www.eyemed.com
Discovery Benefits	Flexible Spending Account	(866) 451-3399	www.discoverybenefits.com
SISC	Employee Assistance Program	(800) 999-7222	www.anthemaeap.com Login Company Code: SISC
Nationwide	My Pet Protection	(877) 738-7874	www.petinsurance.com
United Pet Care	Veterinary Savings Program	(888) 781-6622	www.unitedpetcare.com

District Benefits Team

Conna Bain	Benefits Technician	(626) 585-7719	clbain@pasadena.edu
Cristina Zamora	Benefits and Wellness Coordinator	(626) 585-7503	czamora5@pasadena.edu

Benefits Website: **Benxcel Platform**

Human Resources Website: **<https://pasadena.edu/hr/>**