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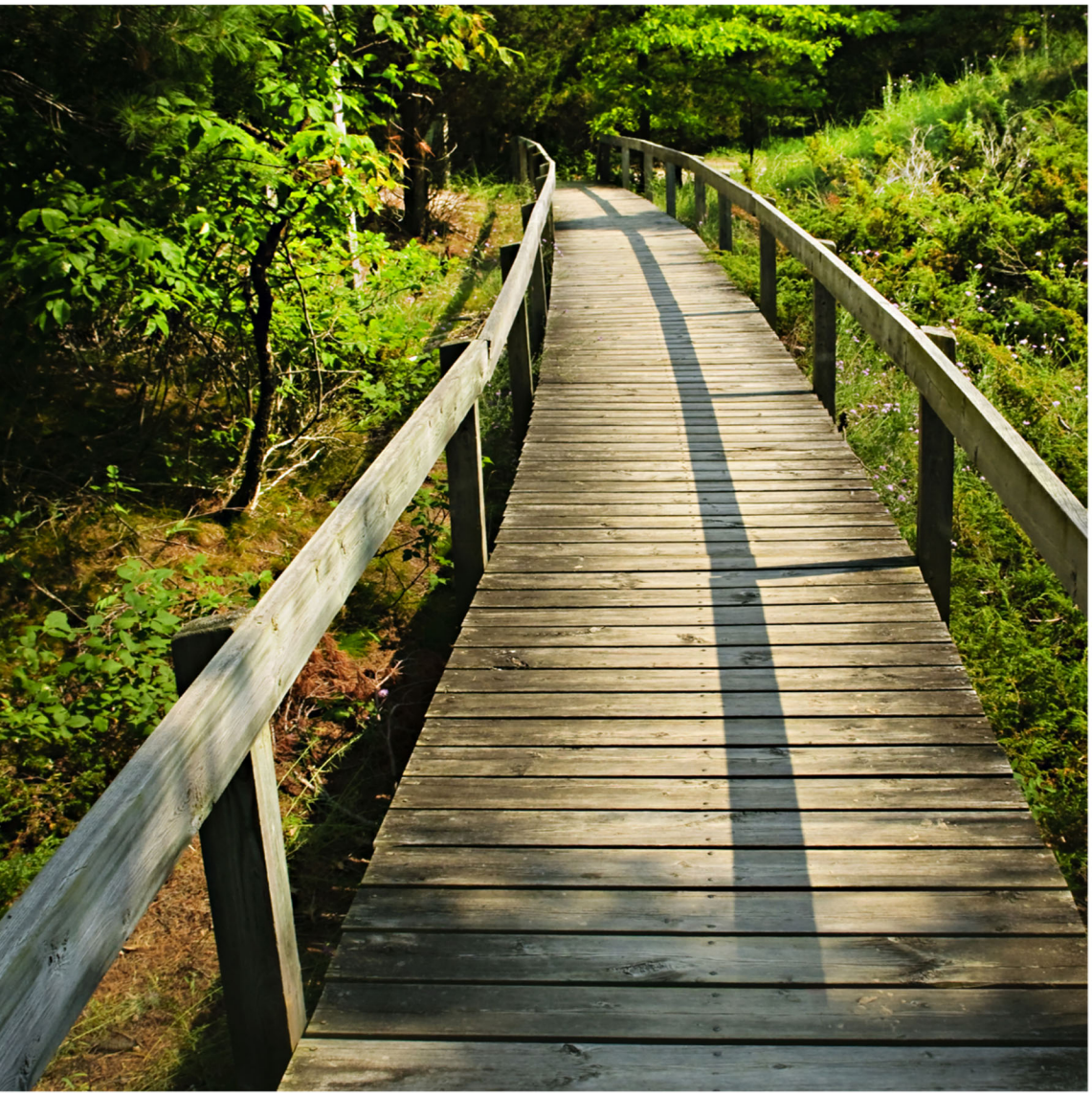

PALOMAR COMMUNITY COLLEGE DISTRICT

EMPLOYEE BENEFITS GUIDE

Open Enrollment

Plan Year: 2021 / 2022

PICK THE BEST BENEFITS FOR YOU AND YOUR FAMILY

The District will conduct Open Enrollment for the 2021/2022 plan year from August 2nd through August 27th, 2021.

This will be your opportunity to elect or make changes for MEDICAL/HSA, DENTAL, VISION, LIFE, AMERICAL FIDELITY FLEXIBLE SPENDING ACCOUNTS, VOLUNTARY PRODUCTS. All plan changes are effective October 1, 2021.

Palomar Community College District wants to make sure you are getting the most out of our benefits—that's why we've put together this Open Enrollment Guide.

Open Enrollment is an annual event when you can review your current benefits and make changes for the coming year. Choose your benefit options carefully, because the choices you make will be in place for the next plan year and cannot be changed unless you experience a life-changing qualifying event.

If you have questions about any of the benefits mentioned in this guide, please do not hesitate contact Human Resources at 760-744-1150 ext. 3053 or ext. 2889; you can also email benefits@palomar.edu.

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WHAT'S NEW/CHANGING

- As of October 1, 2021, the following mandatory change will take effect for the Anthem Blue Cross HMO and PPO medical plans:
  - Skilled nursing facility/inpatient rehabilitation day limit will be 150-day limit per benefit period and will be combined with inpatient rehabilitation services.
- As of October 1, 2021, Anthem PPO plans will have a $0 copay for the first three office visits to a primary care provider each calendar year for each family member enrolled on the plan.

EMPLOYEE CONTRIBUTIONS:

PCCD continues to offer competitive HMO health care plans as well as Kaiser HDHP/HSA at no or low cost to eligible employees. The District will also offer additional Anthem PPO and Delta Dental PPO options at an additional cost. See employee cost on page 4.

The District will automatically set your deductions; if any, on a pre-tax basis unless you choose otherwise.

SELF-INSURED SCHOOLS OF CALIFORNIA (SISC) VALUE ADDED SERVICES

- Advance Medical Opinions: Advance Medical provides members with access to the best health care possible by assisting patients with any and all healthcare questions. The benefit also provides access to medical opinions from world-leading experts without having to leave home. This is available to members at no-cost.
- *MD*Live: Anthem Blue Cross PPO and HMO members can consult with doctors and pediatricians over the phone or using online video for medical conditions such as cough, cold, fever, sore throat, flu, infection, bronchitis, and children's health issues. MDLive physicians can diagnose and prescribe medication when appropriate.
- Free Generic Medication through *Costco*: Anthem Blue Cross HMO and PPO members can receive free generic medications at Costco and through Costco Mail Order (excludes certain pain and cough medications). It is easy—No need to be a Costco member.
- Enhanced Cancer Benefits: Available to Anthem HMO and PPO members. Consult experts who can help you navigate the complex world of cancel treatment. Services include assistance in receiving an accurate initial diagnosis and developing a comprehensive care plan. To find out more about this program you can call 877-220-3556 or go to www.sisc.hdplus.com
- Vida Health: This is a digital coaching app and available to Anthem HMO and PPO members that are 18 and older. Get one-on-one coaching, therapy and other tools and resources via online or mobile access. To find out more about this program you can call 855-442-5885 or go to www.vida.com/sisc
- Hinge Health: This is available to Anthem PPO members. Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy. To find out more about this program you can call 855-902-2777 or go to www.hingehealth.com/sisc

DENTAL PLANS:

PCCD will continue to offer the Delta Dental HMO, Delta Dental PPO, and Delta Dental Incentive plans.

VISION PLAN:

PCCD will continue to offer EyeMed PPO vision plan at no cost to full time benefit eligible employees.

LIFE AND AD&D PLANS:

There will be no changes to the life and AD&D plans.

EMPLOYEE ASSISTANCE PROGRAM (EAP):

PCCD will continue to partner with Anthem Blue Cross for our EAP program. This program is available to all PCCD employees regardless if you are enrolled in Anthem Blue Cross of California, Kaiser Permanente medical plans or waived medical coverage.

The District will offer an additional EAP plan through Voya. The EAP is available to all members of the employee's household.

FLEXIBLE SPENDING ACCOUNT/DEPENDENT CARE:

PCCD will continue to partner with American Fidelity for this program. For additional information (see page 15).

EMPLOYEE CONTRIBUTIONS – 2021/2022

Rates are per paycheck Rates below are based on 12 months payroll*				
Product	**Carrier/Option**	**Monthly Premium (single / 2-party / family)**	**Monthly Employer Contributions (single / 2-party / family)**	**Monthly Employee Cost* (single / 2-party / family)**
Medical	Anthem HMO	$776.00 / $1,515.00 / $2,125.00	$776.00 / $1,515.00/ $2,125.00	$0.00
	Anthem PPO 100A High	$969.00 / $1,893.00 / $2,656.00	$776.00 / $1,515.00/ $2,125.00	$193.00 / $378.00 / $531.00
	Anthem PPO 80E Low	$784.00 / $1,530.00 / $2,147.00	$776.00 / $1,515.00/ $2,125.00	$8.00 / $15.00 / $22.00
	Kaiser HMO	$724.00 / $1,418.00 / $1,990.00	$724.00 / $1,418.00 / $1,990.00	$0.00
	Kaiser HDHP HSA	$491.00 / $963.00 / $1,352.00	$491.00 / $963.00 / $1,352.00	$0.00
Dental	Delta Care HMO	$28.33	$28.33	$0.00
	Delta Dental PPO	$73.20	$28.33	$44.87
	Delta Dental Incentives*	$99.90	$28.33	$71.57
Vision	EyeMed	$14.73	$14.73	$0.00
Basic Life/AD&D	Voya - $80,000/$80,000	$9.52	$9.52	$0.00

*Contributions for employees on 10thly or any other payroll cycle will differ from those listed above. Visit PCCD Benefits webpage or contact benefits@palomar.edu.

WHO IS ELIGIBLE?

If you're a full-time employee, or benefits eligible retiree at Palomar Community College District, you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 20 or more hours per week. Your eligible dependents include:

- Legally Married Spouses and Domestic Partners who have registered with the state of California (must provide copy of state certification)
- Natural or adopted children, stepchildren or children of a domestic partner to age 26, legally placed children for whom you are assigned guardianship up to age 18, and a certified disabled adult child

When covering a spouse or partner, you MUST provide a copy of the front page of your most recent tax return.

HOW DO I ENROLL?

The District will only accept online enrollment for the upcoming open enrollment via the District's employee benefit enrollment secure portal; E-Benefits.

The District will provide you with eBenefits easy to follow user guide. This step-by-step guide will walk you through the login and how to enroll. This guide is available on the District's open enrollment page https://www2.palomar.edu/pages/hr/employees/openenrollment/

You can also enroll via https://enroll.ebenefits.com/login.aspx?id=342

No paper forms will be accepted.

WHEN TO ENROLL

Open enrollment begins on Monday August 2, 2021 and runs through Friday August 27, 2021. The benefits you choose during open enrollment will become effective on October 1, 2021.

WHAT HAPPENS IF I DON'T RE-ENROLL?

If you do not re-enroll, the District will automatically enroll in you and your enrolled dependents in the same plans determined by your current 2020/2021 carrier election. For example, if you are enrolled in the Anthem HMO medical plan and do not take any action during Open Enrollment, you will be auto enrolled in the Anthem HMO plan and the same applies to the dental, vision, and life insurance.

If you are currently enrolled in the Flexible Spending Account/Dependent Spending Account, you must re-enroll during open enrollment. It is an IRS requirement.

OPEN ENROLLMENT EDUCATIONAL WEBINARS

During these webinars, the District and vendors will discuss the plan options and vendors will be available to answer any questions you might have. A link will be provided via email.

Date	Time
Wendesay, August 4, 2021	11:00 am - 12:30 pm
Tuesday, August 10, 2021	11:00 am - 12:30 pm
Thursday, August 19, 2021	9:00 am - 10:30 am
Wednesday, August 25, 2021	1:00 pm - 2:30 pm

STEPS & OPTIONS TO ENROLL

Are you ready to enroll? You can enroll at: https://enroll.ebenefits.com/login.aspx?id=342

- **Step #1:** make sure you review your current benefits. Did you move recently or change in your marital status? Verify all your personal information and make any necessary changes.
- **Step #2:** Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.
- **Step #3:** log into https://www2.palomar.edu/pages/hr/employees/openenrollment/ and start the enrollment process.
- All changes must be made online. No paper forms will be accepted.

If you are currently enrolled or would like to enroll in the flexible spending account, you will need to re-enroll per the IRS requirements. American Fidelity will be sending you a link to schedule an appointment.

CHANGES DURING THE PLAN YEAR/QUALIFYING EVENTS

Benefit coverages are governed by strict IRS guidelines. Based on this, you may only change your benefit elections during open enrollment unless you experience a life-changing qualifying event. You must notify Human Resources Services/Benefits within 30 days of a life-changing qualifying event to make changes. Qualifying events include, but not limited to:

- Marriage, divorce, legal separation or termination of domestic partner
- Birth, adoption, guardianship & custody orders
- Death of spouse, child or another qualified dependent

MEDICAL INSURANCE OPTIONS

The Benefits Committee with the approval of the Board of Trustees and all Bargaining Groups decided to continue offering the current medical insurance plans through Self-Insured Schools of California Joint Power Authority (SISC).

The District will continue to offer group Kaiser Permanente plans (HMO and HDHP/HSA) and group Anthem Blue Cross plans (two PPO and one HMO plans).

The District provides cash incentives for the Kaiser HDHP/HSA.

Kaiser Permanente HSA – Works very similar to an HMO plan but includes a high deductible. **The District will provide an HSA cash incentive*** to cover the annual out of pocket maximum. HSA's are not a use it or lose it account. Should you have funds remaining at the end of the plan year, these funds will roll over year after year. When you retire or terminate employment, the funds in this account go with you. In addition, you can make tax-free contributions towards your HSA via payroll deduction up to the IRS annual limits to use for qualified health expenses and/or savings.

- District incentive for single: $3,000
- District incentive for two party/family coverage: $6,000

Per the IRS guidelines, the deductible and out-of-pocket maximums for the HSA plan will re-set to zero as of January 1, 2022, regardless of the benefit plan year and how much you paid into it between October 1, 2021 and December 31, 2021. Please make sure you plan appropriately as the District contributions will not change.

*Note: the HSA cash incentive amounts will be divided into two sums which will be deposited into the employee's accounts a week after the October 2021 payroll and April 2022 payroll.

MEDICAL INSURANCE OPTIONS (CONTINUED)

The following table outlines a high-level benefit summary of the HMO medical plans offered:

Medical Plan Type/Benefits	Anthem HMO	Kaiser HMO
	In-network only benefit	In-network only benefit
CALENDAR YEAR DEDUCTIBLE AND OUT-OF-POCKET (OOP)		
Individual/Family Deductibles	$0	$0
Individual/Family Out-of-Pocket Max (includes deductibles and co-pays)	$2,000/$4,000	$1,500/$3,000
PROFESSIONAL SERVICES		
Preventive Care Services (includes physical exams & screenings)	No Charge	No Charge
Office Visit/Urgent Care co-pay	$20	No Charge
Specialists/Consultants co-pay	$40	No Charge
Prenatal, postnatal office visit co-pay	$20	No Charge
Scans: CT, CAT, MRI, PET etc.	$100 per test	No Charge
Diagnostic X-ray & Laboratory Procedures	No Charge	No Charge
HOSPITAL & SKILLED NURSING FACILITY SERVICES		
Emergency Room visit (co-pay waived if admitted)[4]	$100/visit	$100/visit
Inpatient Hospital co-pay (preauthorization required)	$250/admit	No Charge
Outpatient Hospital co-pay	$125	No Charge
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	$125	No Charge
Surgery, Outpatient (performed in a Hospital)	$125	No Charge
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT		
INPATIENT CARE: Facility based care (preauthorization required)	$250/admit	No Charge
OUTPATIENT CARE: Physician Office visits	$20	No Charge
OTHER SERVICES		
Acupuncture - Limits apply	$10/30 visits combined w/chiropractic	$10/30 visits combined w/chiropractic
Ambulance (Ground or Air)	$100 co-pay	$50/trip
Chiropractic - Limits apply	$10/30 visits combined w/Acupuncture	$10/30 visits combined w/chiropractic
Durable Medical Equipment (DME)	20% coinsurance	No Charge
Hearing Aids	50% Benefit Allowance/1 device/36 months	Plan Pays up to $500/aid/36 months
Physical and Occupational Therapy - Limits apply	$20	No Charge
PRESCRIPTION DRUG PLANS		
Pharmacy out of pocket maximum	$2,500 Individual / $3,500 Family	
Most Generic co-pay/days supply	$9 or $0 at Costco[1]	$5 up to 100-day supply
Most Brand co-pay/days supply	$35 up to 30-day supply	$5 up to 100-day supply
Most Specialty Drugs - Navitus (most specialty items)	$35 up to 30-day supply	$5 up to 30-day supply
Most Mail Order (Generic/Brand co-pay/days supply)	$0 generics/$90 Brand up to 90 days	$5 mail order

NOTES:

[1] for most generic medications

[2] certain limitation and maximum applies for supplemental DME

This is only a brief summary of benefits that reflects In-Network benefits only. Please review the benefit summaries or plan booklets for details, limitations and exclusions. Plan Booklets will take precedents over this brief summary. Benefits may be subject to change due to mid-year legislative changes.

MEDICAL INSURANCE OPTIONS (CONTINUED)

The following table outlines a high-level benefit summary of the PPO and HDHP H.S.A. medical plans offered:

Medical Plan Type/Benefits	Anthem Traditional PPO PPO 100-A	Anthem Traditional PPO PPO 80-E	Kaiser - Health Savings Account Qualified HMO Plan	
	in-network#	in-network#	Single (in-network)#	Family (in-network)#
CALENDAR YEAR DEDUCTIBLE AND OUT-OF-POCKET (OOP)				
Individual/Family Deductibles	$0	$300/$600	$1,500	$2,800/$3,000
Individual/Family Out-of-Pocket Max (includes deductibles and co-pays)	$1,000/$3,000	$1,000/$3,000	$3,000	$6,000
PROFESSIONAL SERVICES				
Preventive Care Services (includes physical exams & screenings)	0%, Deductible Waived	0%, Deductible Waived	**0% (deductible waived)**	
Office Visit (PCP)/Urgent Care co-pay	$10 (1st 3 PCP visits $0 copay/CY)	$20 (1st 3 PCP visits $0 copay/CY)	10%	
Specialists/Consultants co-pay	$10	$20	10%	
Prenatal, postnatal office visit co-pay	$10	$20	10%	
Scans: CT, CAT, MRI, PET etc.	0%	20%	10%	
Diagnostic X-ray & Laboratory Procedures	0%	20%	10%	
HOSPITAL & SKILLED NURSING FACILITY SERVICES				
Emergency Room visit (co-pay waived if admitted)	$100/visit	$100/visit + 20%	10%	
Inpatient Hospital co-pay (preauthorization required)	0%	20%	10%	
Outpatient Hospital co-pay	0%	20%	10%	
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	0%	20%	10%	
Surgery, Outpatient (performed in a Hospital)	0% (Limitation applies to certain procedures - consult with Anthem)	20% (Limitation applies to certain procedures - consult with Anthem)	10%	
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT				
INPATIENT CARE: Facility based care (preauthorization required)	0%	20%	10%	
OUTPATIENT CARE: Physician Office visits	$10	$20	10%	
OTHER SERVICES				
Acupuncture - Limits apply	0%	20%	Not covered	
Ambulance (Ground or Air)	$100 co-pay	$100 co-pay + 20%	10%	
Chiropractic - Limits apply	0%	20%	Not covered	
Durable Medical Equipment (DME)	0%	20%	10%[2]	
Hearing Aids	10% Coinsurance ($700 per benefit allowance every 24 months)	20% Coinsurance ($700 per benefit allowance every 24 months)	Not covered	
PRESCRIPTION DRUG PLANS				
Pharmacy out of pocket maximum	$1,500 Individual / $2,500 Family	$2,500 Individual / $3,500 Family	Medical Deductible has to be met	
Most Generic co-pay/days supply	$5/$0 at Costco[1]	$9/$0 at Costco[2]	$10 up to 30-day supply	
Most Brand co-pay/days supply	$20 up to 30-day supply	$35up to 30-day supply	$30 up to 30-day supply	
Most Specialty Drugs - Navitus (most specialty items)	$20 up to 30-day supply	$35 up to 30-day supply	$30 up to 30-day supply	
Most Mail Order (Generic/Brand co-pay/days supply)	$0 generics/$50 Brand up to 90 days	$0 generics/$90 Brand up to 90 days	$20 generic/$60 Brand up to 100-day supply	

NOTES:

[#] SISC PPO plans offer some out-of-network coverage. Please refer to the Benefit Summary

[1] for most generic medications

[2] certain limitation and maximum applies for supplemental DME

[3] Amounts will be deposits in two increments, October 2021 and April 2022

[4] Members is responsible for excess out of network provider charges

This is only a brief summary of benefits that reflects In-Network benefits only. Please review the benefit summaries or plan booklets for details, limitations and exclusions. Plan Booklets will take precedents over this brief summary. Benefits may be subject to change due to mid-year legislative changes.

DENTAL INSURANCE OPTIONS

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

This District will continue to offer two dental plans: DHMO and DPPO. The DHMO plan will be offered at no cost to employees. Employees will pay for the following plans via payroll deduction: Delta DPPO and Delta Dental Incentive Plan (for employees hired prior to 1994). See employee rates on page 4.

Dental Plan Type/Benefits	Delta Dental PPO			Delta Dental DHMO
	PPO Network	Premier Network	Out-of-Network	In-Network Only
Annual Deductible (Individual / Family)	$0	$25	$25	$0
Waived for Preventive		No		N/A
Annual Plan Maximum	$1,500	$1,500	$1,500	N/A
Covered Services				
Diagnostic and Preventive Services	100%	90%	90%	Copays vary
Basic Services	90%	70%	70%	Copays vary
Major Services	60%	50%	50%	Copays vary
Crowns and Cast Restorations	60%	50%	50%	Copays vary
Prosthodontics	60%	50%	50%	Copays vary
Orthodontia Services				
Orthodontia Maximum	$1,000 (lifetime maximum)			Limited ortho (under 19) $950 copay Limited ortho (adult) $1,150 copay Comprehensive ortho (under 19) $1,300 copay Comprehensive ortho (adult) $1,600 copay
Adult & Dependent Children	50%	50%	50%	Copays vary

Dental Plan Type/Benefits	Delta Dental Incentive (This plan is only availavle if you were hired at PCCD prior to 1994)		
	PPO Network	Premier Network	Out-of-Network
Annual Deductible (Individual / Family)	$0	$0	$0
Waived for Preventive	N/A	N/A	N/A
Annual Plan Maximum	$1,500	$1,500	$1,500
Covered Services			
Diagnostic and Preventive Services	70-100%	70-100%	70-100%
Basic Services	70-100%	70-100%	70-100%
Major Services	70-100%	70-100%	70-100%
Crowns and Cast Restorations	70-100%	70-100%	70-100%
Prosthodontics	50%	50%	50%
Orthodontia Services			
Orthodontia Maximum	Not covered		
Adult	Not covered	Not covered	Not covered
Dependent Children	Not covered	Not covered	Not covered

NOTE: If you are currently enrolled in the Delta Dental Incentive plan (only available to those hired prior to 1994) and you elect to move to the either the Delta Dental PPO or Delta Dental DHMO, you may not return to the Delta Dental Premier plan at a later time.

This is only a brief summary of benefits that reflects In-Network benefits only. Please review the benefit summaries or plan booklets for details, limitations, and exclusions. Plan Booklets will take precedents over this brief summary. Benefits may be subject to change due to mid-year legislative changes.

VISION INSURANCE

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

EyeMed's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

To find a provider visit www.eyemed.com; find a provider; choose Insight Network.

Vision Plan Type/Benefit	EyeMed Vision	
	In-Network	Out-of-Network Member Reimbursement up to:
Exam Copay	$0	Up to $40
Frequency:		
Eye Exam	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 12 months
Contacts	Once every 12 months (in lieu of lenses)	Once every 12 months (in lieu of lenses)
Lenses:		
Single Vision	$0	Up to $30
Bifocal	$0	Up to $50
Trifocal	$0	Up to $70
Lenticular	$0	Up to $70
Standard Progressive	$0	Up to $108
Premium Progressive Tier 1	$20	Up to $108
Premium Progressive Tier 2	$30	Up to $108
Premium Progressive Tier 3	$45	Up to $108
Premium Progressive Tier 4	$0 copay; 20% off retail less$120 Allowance	Up to $108
Contact Lenses:		
Conventional	$0 copay; $180 Allowance, 15% off balance over $180	Up $180
Disposable	$0 copay; $180 Allowance, plus balance over $180	Up $180
Medically Necessary	$0 copay, Paid in Full	Up to $210

This is only a brief summary of benefits that reflects In-Network benefits only. Please review the benefit summaries or plan booklets for details, limitations and exclusions. Plan Booklets will take precedents over this brief summary. Benefits may be subject to change due to mid-year legislative changes.

DISABILITY INCOME INSURANCE BENEFITS

Palomar Community College District provides full-time eligible employees with long-term disability income benefits through Voya. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

This benefit replaces California State Disability Benefits and includes a 90-day elimination period. Employees are required to use their sick-leave during the elimination period.

Disability Plan Type/Benefit	**VOYA**	
	Long Term Disability	
Class	**Class Description**	**Eligibility**
	All full time active employees and permanent part time employees who are certificated employees under the STRS plan, full time or part time non-certificated employees.	All full time active employees working 20+ or more hours per week
Benefits		
Monthly Benefit	66.67%	
Maximum Monthly Benefit	$7,500	
Minimum Monthly Benefit	>$100 or 10%	
Definition of Earnings	Base Salary	
Elimination Period (EP)	90 days	
Accumulation of EP	2x's Elimination Period	
Maximum Duration	Social Security Normal Retirement Age (SSNRA)	
Definition of Disability	2 years own occupation, with residual	
Return to Work Incentive	12 months	
Pre-Existing Limit	3/12	
Mental Illness Limit	24 months	
Alcoholism or Drug Abuse Limit	24 months	
Special Condition Limit	Unlimited	
Survivor Benefit	3 months	
Child or Family Member Care Expense Benefit	24 months / $500	
Vocational Rehabilitation Benefit	5% or $500	

This is only a brief summary of benefits that reflects In-Network benefits only. Please review the benefit summaries or plan booklets for details, limitations and exclusions. Plan Booklets will take precedents over this brief summary. Benefits may be subject to change due to mid-year legislative changes.

BASIC LIFE INSURANCE

Palomar Community College District Life insurance can help provide for your loved ones if something were to happen to you. The District provides full-time eligible employees with $80,000* in group life and accidental death and dismemberment (AD&D) insurance through Voya.

The District pays for the full cost of this benefit. Contact the benefits department at benefits@palomar.edu if you need update beneficiary information.

*Per the IRS guidelines, employee is responsible for imputed income on any amount over $50,000.

SUPPLEMENTAL LIFE INSURANCE

While the District offers basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

With supplemental life insurance, you are responsible for paying the full cost of coverage through payroll deductions. You can purchase coverage for yourself, your spouse in $10,000 increments. The minimum coverage level is $10,000 and the maximum is $300,000 not to exceed 5 times salary. The maximum you can purchase for your spouse is 50% of the amount you purchase for yourself; maximum of $100,000

You can also purchase coverage for your child(ren) up to $10,000.

EMPLOYEE/SPOUSE LIFE ONLY RATE INFORMATION

- The rate is based on the employee's age on October 1 of every year and will automatically increase when you advance into the next age bracket. Spouse rates will be based on employees age.
- Life rates are calculated assuming you receive 12 paychecks per year (if you are paid on a different pay cycle, the rates will be adjusted)

Voya	
Supplemental Life	
Age	Rate/$10,000
Under 20	$0.45
20-24	$0.45
25-29	$0.45
30-34	$0.63
35-39	$0.81
40-44	$0.99
45-49	$1.80
50-54	$3.15
55-59	$5.31
60-64	$8.55
65-69	$12.06
70+	$17.82

Coverage amount reduces to 50% at age 70. Coverage terminates at retirement

DEPENDENT CHILDREN LIFE RATE INFORMATION

If you are covered for supplemental life, you may enroll your qualified child(ren) in $10,000 coverage for $0.75 per month.

SUPPLEMENTAL LIFE INSURANCE (CONTINUED)

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Each eligible employee and their dependents may purchase additional amounts of coverage on a supplemental basis. To enroll in AD&D, the participant is required to be enrolled in the supplemental life insurance coverage.

Voya Supplemental AD&D	
	Rate/$10,000
Employee	$0.40
Family	$0.63

Coverage amount reduces to 50% at age 70. Coverage terminates at retirement

EXAMPLE

Ann Smith is a 35-year-old who applies for $100,000 of Supplemental Life Coverage.

Steps to calculate her supplemental coverage:

- $100,000 divided by 10,000 = 10
- 10 times $0.81 = $8.10
- Her monthly premium for $100,000 of supplemental life is $8.10

ADDITIONAL SERVICES THROUGH VOYA FOR PALOMAR COMMUNITY COLLEGE DISTRICT EMPLOYEES - AT NO ADDITIONAL COST

- Travel Assistance
- Funeral Planning and Concierge Services
- EAP Services

FLEXIBLE SPENDING ACCOUNTS

The District will continue to offer an FSA plan through American Fidelity. You will need to re-enroll on an annual basis during open enrollment to continue on this benefit. The election you make during this open enrollment will take effect on October 1, 2021.

WHAT IS A HEALTH CARE FSA?

HealthCare FSAs allow you to contribute pre-tax dollars to qualified health care related expenses. The maximum amount you may contribute for 2021/2022 is $2,750.

WHAT IS A DEPENDENT CARE FSA?

Dependent Care FSAs allow you to contribute pre-tax dollars to qualified dependent care. The maximum amount you may contribute each year is $5,000 (or $2,500 if married and filing separately).

HOW DO I ENROLL?

Even if you signed up last year, you must re-enroll for 2021/2022. American Fidelity will send you a link to schedule an appointment to meet with them in late August, watch for the email!

FSA SAVINGS EXAMPLE

Bob and Jane's combined gross income is $30,000. They have two children and file their income taxes jointly. Since Bob and Jane expect to spend $2,000 in adult orthodontia and $3,300 for day care next plan year, they decide to direct a total of $5,300 into their FSAs.

EMPLOYEE ASSISTANCE PROGRAM

To help you perform at your peak and get the most out of life, the EAP is offered to all employees and their families. This free, completely confidential service is administered by Anthem, and is available 24 hours a day, every day. The EAP can help with personal topics such as:

- Family relationships
- Stress and grief
- Legal or financial assistance
- Child or adult day care
- Drug and alcohol dependency
- Eating disorders

Sometimes a phone call is all it takes, but you can schedule an appointment with an EAP counselor; the District's plan will pay for up to six sessions per person per incident each year. The EAP can also provide referrals to other providers or community resources.

HOW DO I ACCESS THE EAP BENEFIT?

You can call (800) 999-7222 and speak with a professional EAP representative or counselor,

You can chat line online with a team member, go to anthemeap.com to use LiveCONNECT instant messaging or,

You can go online at anthemeap.com for articles, educational materials, tips, tools and more.

NOTE: When accessing the EAP services, please let them know you are with Palomar Community College District and your EAP plan is through Self-Insured Schools of California Joint Power Authority (SISC). Additionally, you also have access to Voya EAP program as well.

ADDITIONAL BENEFIT OFFERINGS

As an employee of Palomar Community College District, you are also eligible to enroll or participate in the following voluntary programs:

- American Fidelity products such as Flexible Spending Accounts, Cancer, Accident, Short Term Disability and Life policies. For more information contact Dana Vampola (800) 365-9180 or email her at dana.vampola@americanfidelity.com.

- Aflac Products such as Cancer, Accident, Short Term Disability, Vision and Life policies. For more information contact Paul Steinbrenner (760) 845-7280.

- Hyatt Legal Services.

- 403(b), 457(b) and Roth 403(b). For more information contact Joel Romero at (619) 823-1641 or email him at eric.winston@empower-retirement.com.

- Ability to increase your Unum long-term care coverage. Contact the benefit department for any questions.

QUESTIONS & ANSWERS

HOW CAN I ENROLL AND WHEN IS THE FINAL DATE TO ENROLL/MAKE CHANGES?

You can enroll and/or make changes at: https://enroll.ebenefits.com/login.aspx?id=342
Or you can go through the District website https://www2.palomar.edu/pages/hr/employees/openenrollment/ and click on the link to enroll.

If you do not have access to a computer, you can drop by the Benefit Department, and they would be able to guide through the process. (Is this option still available?)

No paper forms will be accepted.

WILL MY BENEFIT ELECTION AUTOMATICALLY ROLLOVER TO THE NEXT PLAN YEAR?

Yes, except the Flexible/Dependent Spending Accounts. If you are enrolled in a plan that requires employee contributions, your premium will be adjusted to reflect the new contribution amount.

You must enroll during Open Enrollment in the FSA plans per the IRS code. To add an FSA plan, contact Dana Vampola/American Fidelity at (800) 365-9180. To add an HSA account, you will need to contact the Benefits Department at 760-744-1150 x 3053 or x 2889. Note: Adding an HSA requires enrollment in a HDHP medical plan.

CAN I RE-ENROLL IN MY BENEFITS VIA PAPER FORMS?

No. All enrollment changes will need to be conducted via Palomar Community College District Open Enrollment Website https://www2.palomar.edu/pages/hr/employees/openenrollment/

Open enrollment is open until 3:00 PM Friday, August 27, 2021.

CAN I PICK AN HMO PLAN FOR MYSELF AND A DIFFERENT PLAN FOR MY FAMILY?

No, the employee and dependents must join the same plans.

CAN YOU RECOMMEND A PLAN FOR ME AND MY FAMILY?

Since health plans are a personal choice, we recommend that you are review all the options and pick the plan that fits you and your family needs. The Benefit Department would be happy to discuss the options, but the ultimate choice is yours.

WHAT IF I MISS THE OPEN ENROLLMENT PERIOD FOR BENEFITS?

If you miss the open enrollment period, you will not be able to enroll or make changes until the next open enrollment period – unless you experience a qualifying life event (see page 6).

I HAVE ANTHEM PPO PLAN AND I HAD OUT OF NETWORK SERVICES AND I WOULD LIKE TO REQUEST REIMBURSEMENT?

You will need to submit out of network claims within 6 months of the services date to Anthem. Claims will be denied for timeliness, so you should not wait to submit the claim.

MY SPOUSE LOST HIS/HER JOB 10 DAYS AGO, CAN I ADD HIM TO MY HEALTH CARE COVERAGE?

Yes, this is considered a qualifying event, but you will need to inform the Benefit Department no later than 30 days from the event, otherwise he/she will have to wait until next open enrollment unless you have another qualifying event.

HOW DO DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS WORK?

Your deductible is the amount you must contribute prior to your insurance kicking in. In the case of high deductible health plans such as Kaiser HSA, everything comes out of your pocket until you hit this dollar amount, at which point co-insurance kicks in until you reach your out-of-pocket maximum. The District does contribute to your maximum out of pocket for Kaiser HDHP/HSA plans so that will cover that amount.

In the case of more traditional health plans such as the Anthem PPO plans, other services may be covered beforehand (with a copay), such as primary care or specialist visits.

The out-of-pocket maximum is the highest amount you can be expected to pay in out-of-pocket expenses in a given year, including your deductible and coinsurance.

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

See page 7 of this guide.

I JOINED THE KAISER HSA PLAN AS OF 10/1/2021 AND MET MY DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM BY 12/11/2021. I JUST NOTICED THAT BOTH MY DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM IS RE-SET TO ZERO ON 01/11/2022, WHY?

Per the IRS guidelines, the deductible and out-of-pocket maximums for the HSA plan will re-set to zero as of January 1, 2022, regardless of the benefit plan year and how much you paid into it between October 1, 2021 and December 31, 2021. Please make sure you plan appropriately as the District contributions will not change.

WHAT IS THE AGE LIMIT TO JOIN THE KAISER HIGH DEDUCTIBLE PLAN?

Most individuals become eligible for Medicare at age 65. Participation in any type of Medicare (Part A, Part B, Part C - Medicare Advantage Plans, Part D, and Medicare Supplement Insurance - Medigap), makes you ineligible to contribute to an HSA per the IRS guidelines. However, you can continue to "use" your HSA funds for qualified medical expenses and other expenses; see IRS guidance on allowed expenses, for as long as you have funds in your HSA account.

Example. Sally turns 65 on July 21 and enrolls in Medicare. She is no longer eligible to contribute to her HSA as of July 1. Her maximum contribution for that year would be 6/12 (she was eligible the first 6 months of the year starting January 1st) times the applicable federal limit.

I HAVE ANTHEM PPO PLAN AND I HAVE OUT OF NETWORK SERVICES. I WOULD LIKE TO REQUEST REIMBURSEMENT, IS THERE A TIMELINE TO SUBMIT THESE CLAIMS?

You will need to submit out of network claims within 6 months of the service date to Anthem. Claims will be denied for timeliness, so you should not wait to submit the claim.

Annual Required Notifications

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

Under the Women's Health and Cancer Rights Act of 1998, when a person insured for benefits under your health plan who has had a mastectomy (at any time) decides to have breast reconstruction, based on consultation between the attending physician and the patient, the following benefits will be subject to the same coinsurance and deductibles that apply to other medical and surgical benefits provided under the Plan:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications in all stages of mastectomy, including lymphedemas.

Please refer to your EOC for more information on deductibles and coinsurance. If you have any questions about your benefits under your health plan, please contact your health plan or the Human Resources Department.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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).

REMINDER OF AVAILABILITY OF HIPAA PRIVACY NOTICE

This notice is to remind plan participants and beneficiaries of the Palomar CCD health plans in accordance with the Health Insurance Portability and Accountability Act (HIPAA), the Plans maintains policies and practices to protect the confidentiality of protected health information (PHI) it receives about you and your covered dependents. These policies and practices are documented in the Palomar CCD Health Plan Privacy Notice.

You can obtain a paper copy of this Notice free of charge upon your written request to the Plan Privacy Officer at the following address:

Palomar Community College District
1140 W Mission Rd.
San Marcos, CA 92069
(760) 744-1150

For a copy of the HIPAA Privacy Notice applicable to your fully insured health care plan(s), please contact your insurance carrier. Contact information for Palomar CCD's insurance carrier is listed in your Summary Plan Description (SPD).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage.

However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. To request special enrollment or obtain more information, contact Wendy Corbin.

IMPORTANT NOTICE 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 Palomar CCD 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. Palomar CCD has determined that the prescription drug coverage offered by Palomar CCD Medical Plan is, on average for all plan participants, expected to payout 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 through December 7th.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE (CONTINUED)

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 and drop your current Palomar CCD prescription drug coverage, be aware that you and your dependents will not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

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 Palomar CCD 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 November to join.

More Information About Your Options Under Medicare Prescription Drug Coverage

Contact the office 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 Palomar CCD changes. You also may request a copy of this notice at any time.

For More Information About This Notice or Your Current 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 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
- Call1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325- 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, 2021
Name of Entity	Palomar Community College District
Address	1140 W Mission R. San Marcos, CA 92069
Phone Number	760-744-1150

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 outside of California you may 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).

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)
OMB Control Number 1210-0137 (expires 12/31/2019)

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

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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.

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA (CONTINUED)

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- 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 coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA (CONTINUED)

Medical:
Self-Insured Schools of California (SISC III)
P.O. Box 1847
Bakersfield, CA 93303-1847

Delta Dental PPO:
Alameda County Schools Insurance Group (ACSIG)
P.O. Box 2487
Bakersfield, CA 94568

All COBRA applications/payment and forms should go directly to Palomar CCD for processing at the address below
Other Benefits excluding Medical & Delta Dental PPO:
Palomar Community College District
1140 W Mission Rd.
San Marcos, CA 92069
(760) 744-1150

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.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage. To request an extension due to disability, please notify:

Medical:

Benefits excluding Medical & Delta Dental PPO:
Self-Insured Schools of California (SISC III)
P.O. Box 1847
Bakersfield, CA 93303-1847

Delta Dental PPO:
Alameda County Schools Insurance Group ACSIG)
P.O. Box 2487
Bakersfield, CA 94568

Other
Palomar Community College District
1140 W Mission Rd.
San Marcos, CA 92069
(760) 744-1150

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. 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.

If you have questions…

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, 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 or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov. Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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.

Medical:
Self-Insured Schools of California (SISC III)
P.O. Box 1847
Bakersfield, CA 93303-1847

Delta Dental PPO:
Alameda County Schools Insurance Group (ACSIG)
P.O. Box 2487
Bakersfield, CA 94568

Other
Palomar Community College District
1140 W Mission Rd.
San Marcos, CA 92069
(760) 744-1150

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB 1210-0149
(expires No. 4-30-2017)

PART A: GENERAL INFORMATION

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2021 for coverage starting as early as January 1, 2022.

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

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

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

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

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

How Can I Get More Information?

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

For more information about your coverage offered by your employer, please check your summary plan description or contact: Wendy Corbin, Benefits Specialist at 760.744.1150 or wcorbin@palomar.edu.

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

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name Palomar Community College District		3. Employer Identification Number (EIN) 95-6002227
5. Employer address: 1140 W. Mission Road		6. Employer phone number: 760.744.1150
7. City: San Marcos	8. State: CA	9. ZIP code: 92069
10. Who can we contact at this job? Wendy Corbin, Benefit Specialist at 760.744.1150 x- 2889		
11. Phone number (if different from above	12. Email address wcorbin@palomar.edu	

Here is basic information about health coverage offered by Palomar Community College District.

- As your employer, we offer a health plan to:
  - ☑ All employees. Eligible employees are:

    Classified and Management Employees working a minimum of 20 hours per week and a minimum of 30 hours per week for Certified Employees

  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Legal Spouse, registered domestic partner, and children to the age of 26.

  - ☐ 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 wage.

** 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 loses, 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.

If you are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Contact Information

District Benefits/Insurance Carriers /Administrators

Palomar Community College District Benefit Department

Wendy Corbin	Benefits Specialist	(760) 744.1150 x-2889	email: wcorbin@palomar.edu
Veronica Sadowski	BenefitS Specialist	(760) 744.1150 x-3053	email vsadowski@palomar.edu

You can also contact benefits@palomar.edu for any questions you have

Anthem Blue Cross of California

HMO Customer Service	(800) 227.3771
PPO Customer Service	(800) 288.2539
Costco Mail Order	(800) 607.6861
Specialty Pharmacy - Navitus	(855) 847.3553

www.anthem.com/ca
www.navitus.com

Kaiser California

Customer Service	(800) 464.4000
Mail Order Pharmacy	(866) 523.6059

www.kp.org

EyeMed Vision

Customer Service	(866) 939.3633

www.eyemed.com

Delta Dental PPO

Delta Dental PPO	(866) 499.3001

www.deltadentains.com

DeltaCare Dental HMO

Customer Service	(800) 422.4234

www.deltadentalins.com

Employee Assistance Program

Customer Service	(800) 999.7222

www.anthemeap.com

Voya Life & Disability

Life and AD&D	(888) 238.4840
Long Term Disability	(888) 305.0602
Travel Assistance	(800) 659.2821
Funeral Planning & Concierge Services	(800) 913.8318

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact benefits@palomar.edu.

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