PALOMARPOWERED

Palomar Community College District

OPEN ENROLLMENT PRESENTATION

Plan Year: 2022 – 2023

Individuals requiring sign-language Interpreters, real-time captioners, or other accommodations should contact the Benefits Department at (760) 744-1150, et. 3053 or benefits@palomar.edu two weeks in advance of the event or five days in advance for a workshop. Visit the Human Resource Services Benefits for the online Interpreting/Captioning Request Form or access it here Accessibility Services – Human Resource Services (palomar.edu)

Focus on Wellness!

Think like a Monk, train your mind for peace and purpose every day. By Jay Shetty

- "It's helpful to draw a contrast between the monk mindset and the ancient Buddhist concept of the monkey mind." p. xvi-xvii

Monkey Mind	Monk Mind
Overwhelmed by multiple branches	Focused on the root of the issue
Amplifies negatives and fears	Works on breaking down negatives and fears
Looks for temporary fixes	Looks for genuine solutions

- **"Don't panic! Use your breath to realign body and mind"**

  "Breathe to calm and relax yourself" p. 60

  1. Inhale through the nose slowly to a count of 4
  2. Hold for a count of 4
  3. Exhale slowly through the mouth to a count of 4 or more
  4. Repeat until you feel your heart rate slow down

The Upside of Stress, why stress is good for you and how to get good at it. By Kelly McGonigal

- "…different ways of dealing with stress lead to very different outcomes. When you face difficulties head-on, instead of trying to avoid or deny them, you build your resources for dealing with stressful experiences. You become more confident in your ability to handle life's challenges. You create a strong network of social support. Problems that can be managed get taken care of, instead of spiraling out of control. Situations that you can't control become opportunities to grow. In this way, as with many mindsets, the belief that stress is helpful becomes a self-fulfilling prophecy." p. 18
- Kelly McGonigal, TEDGlobal 2013, *How to make stress your friend*

Added Wellness Benefits through SISC

Kaiser Member Benefits	Anthem Member Benefits
Kaiser Your Care Your Way	Anthem Membership Discounts (HMO & PPO)
Kaiser Wellness Coaching	MD Live virtual care med/behavioral (HMO & PPO)
Kaiser Total Health Assessment	Vida Health Coaching (HMO & PPO)
Kaiser Telehealth	Anthem Active & Fit
Kaiser Active & Fit	MyStrength through the EAP (HMO & PPO)
MyStrength through the EAP	Teledoc Expert Second Opinion/Advice (HMO&PPO)
Teledoc Expert Second Opinion/Advice	Hinge Health (PPO only)
	Maven Maternity Benefit (PPO only)
	Cancer Diagnosis Benefit (PPO only)

Presentation Table of Contents

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- ✓ Action needed
- ✓ 2022/2023 Contributions
- ✓ Pre-Tax vs. Post-Tax deduction examples
- ✓ Insurance Plan Information
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Overview

The District remains committed to providing permanent employees with comprehensive benefits, including plans with 100% District paid premiums.

Medical/Dental/Vision/Life/Long Term Care Plans – 100% District paid premiums
Anthem HMO for the Employee and Eligible Dependents
Anthem PPO 80E for the Employee and Eligible Dependents
Kaiser HMO for the Employee and Eligible Dependents
Kaiser HDHP/Wex HSA District contributions of $3,000 single / $6,000 2-party & family Discovery Benefits HSA funds deposited half in October/half in April.*
DeltaCare DHMO for the Employee and Eligible Dependents
EyeMed Vision for the Employee and Eligible Dependents
$80,000 VOYA Employee Term Life Insurance and Accidental Death & Disability Insurance
Unum Employee Long Term Care Insurance
Anthem & VOYA Employee Assistance Programs for ALL employees and their household members

Medical and Dental PPO plans – Employee Contributions Required
Anthem PPO 100A plan for the Employee and Eligible Dependents
Delta PPO and Delta Premier Incentive for the Employee and Eligible Dependents

* Per the IRS HDHP/HSA Deductible & Out-of-Pocket maximum will reset on January 1st regardless of benefit plan year

What is New?

"Learn to Live" EAP benefit is available for all district employees (Anthem EAP)

Customized online programs based on Cognitive Behavioral Therapy principles

Program is confidential, accessible anywhere, and employees learn effective ways to manage stress, depression, anxiety, substance use, and sleep issues

Program is divided into eight online lessons, each describing new tools to help participants develop new healthy habits

New Anthem PPO Benefits

"No Surprises Act" – Out-of-Network balance billing for emergency services, non-emergency items and services provided by in-network facilities, post-stabilization care at out-of-network facilities until a patient can be transferred to an in-network facility, and out-of-network air ambulance healthcare is no longer permitted under this law.

Maven Maternity Care – Offers 24/7 virtual access to one-on-one maternity and postpartum support. Members are matched with a Care Advocate who connects them to resources.

80E PPO is now 100% employer paid with no employee contribution required.

New Kaiser Benefits

Calm Meditation and Mindfulness smart phone application (kp.org/selfcareapps)

Action Needed

<u>Benefit Changes Needed</u>:

View and enroll online at http://www.ebenefits.com/palomar (Select "Register Now!" data was reset)

- Select "enroll now"
- View current benefits in the "shopping cart"
- Update the coverage/information you wish to change
- Review your elections in the "shopping cart"
- Respond to Terms & Conditions and click "Submit Enrollment"
- A selection confirmation will display (print and/or save)

<u>No Benefit Changes</u>:

No action is required during Open Enrollment

Flexible Spending Account participants must re-enroll each year with an American Fidelity representative

October 2022-September 2023 Contributions

Plans Requiring Employee 10 or 12 Monthly Contributions				
Insurance Plan	2021/2022 Employee Contribution		2022/2023 Employee Contribution	
Coverage:	12 Month Contribution	10 Month Contribution	12 Month Contribution	10 Month Contribution
Anthem Traditional PPO 100A	Single $193.00 2-Party $378.00 Family $531.00	Single $231.60 2-Party $453.60 Family $637.20	Single $184.00 2-Party $359.00 Family $505.00	Single $220.80 2-Party $430.80 Family $606.00
Anthem PPO 80E	Single $8.00 2-Party $15.00 Family $22.00	Single $9.60 2-Party $18.00 Family $26.40	**New this year** $0	**New this year** $0
Delta Dental PPO	Single, 2-Party, Family $44.87 (*)	Single, 2-Party, Family $53.84 (*)	Single, 2-Party, Family $44.87 (*)	Single, 2-Party, Family $53.84 (*)
Delta Dental Premier	Single, 2-Party, Family $71.57 (*)	Single, 2-Party, Family $85.88 (*)	Single, 2-Party, Family $71.57 (*)	Single, 2-Party, Family $85.88 (*)

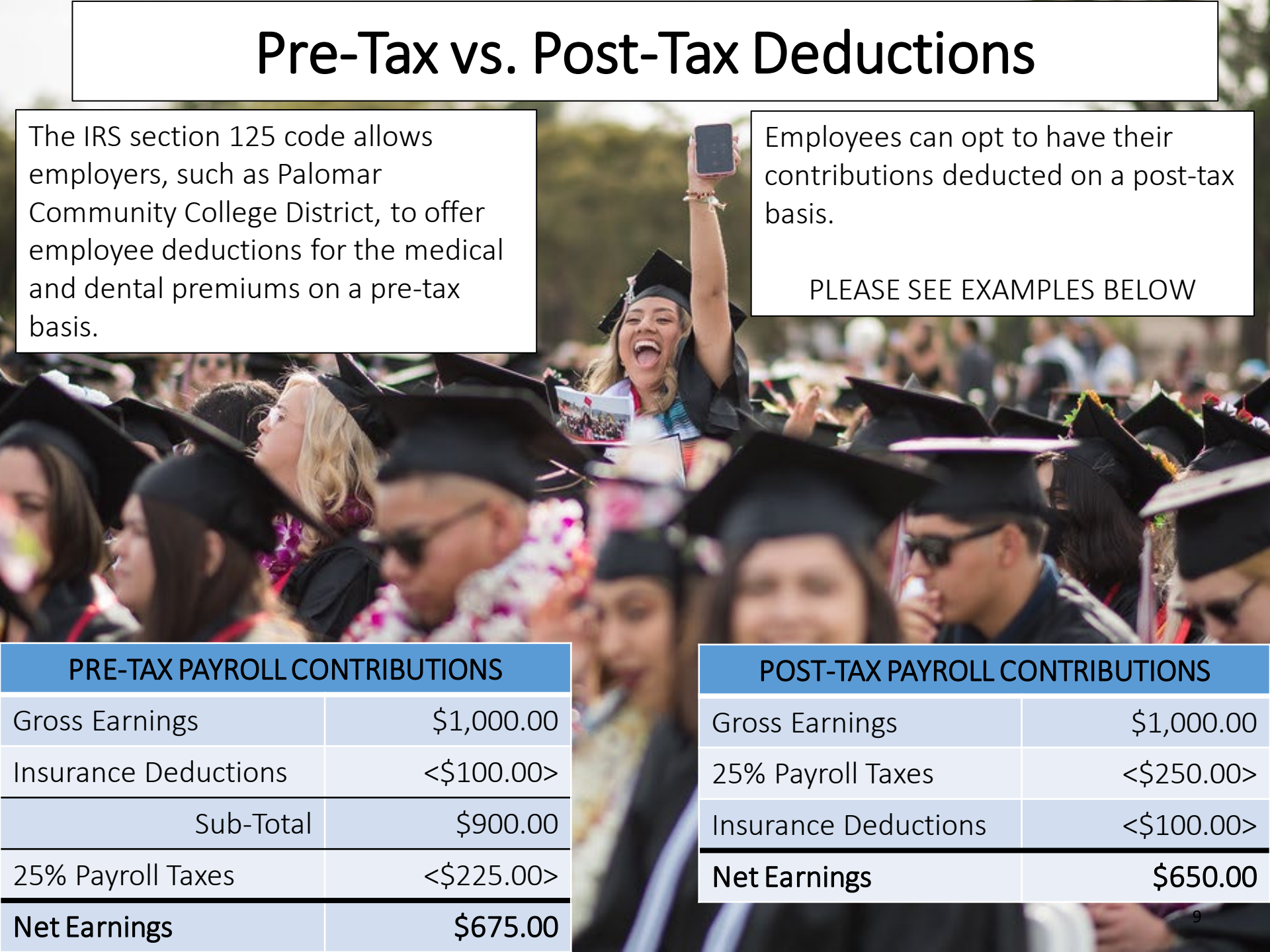
The District contributes 100% to Kaiser HMO&HDHP, Anthem HMO&PPO80E, EyeMed vision plan, Long Term Care and Basic Life coverage.
(*) Dental rates are based on super-composite structure.

Pre-Tax vs. Post-Tax Deductions

The IRS section 125 code allows employers, such as Palomar Community College District, to offer employee deductions for the medical and dental premiums on a pre-tax basis.

Employees can opt to have their contributions deducted on a post-tax basis.

PLEASE SEE EXAMPLES BELOW



PRE-TAX PAYROLL CONTRIBUTIONS	
Gross Earnings	$1,000.00
Insurance Deductions	<$100.00>
Sub-Total	$900.00
25% Payroll Taxes	<$225.00>
Net Earnings	**$675.00**

POST-TAX PAYROLL CONTRIBUTIONS	
Gross Earnings	$1,000.00
25% Payroll Taxes	<$250.00>
Insurance Deductions	<$100.00>
Net Earnings	**$650.00**

Medical Plan Options

2022 – 2023

(Effective October 1, 2022)

Medical **(through SISC III JPA)**	• Anthem Blue Cross HMO California Care • Anthem Blue Cross PPO 100A • Anthem Blue Cross PPO 80E • Kaiser Permanente HMO • Kaiser Permanente HDHP with H.S.A.

The HMO Plans

Key features

- Primary Care Provider and medical group provide standard medical care
- Service costs are predictable
- Your out-of-pocket costs are usually lower when you get care

Things to consider

- This plan only covers services from doctors in the **health maintenance organization** (HMO) plan, for an emergency out-of-network providers are covered as in-network
- Your plan requires you to select a primary care physician (PCP) and medical group (you can change your PCP and medical group on a monthly basis, but you need to contact Anthem or Kaiser before you seek services from the new PCP or medical group otherwise services will not be covered)
- If you need a specialist, you'll have to go through your primary care doctor to get a referral. In most cases, you will be sent to a specialist within the medical group

HMO – Care Away From Home

Do you have dependents who reside outside of California?

You and your dependents are covered for emergency services anywhere in the US and the world.

Anthem:

If so, they may be able to enroll for HMO coverage with a partner Anthem Blue Cross plan under their Guest Membership program. The HMO Away From Home Care program gives you Guest Membership if they will be temporarily outside of your service area for at least 90 days in one location.

Memberships are available if there is a participating Plan in your location. If it happens that the area you will be in does not have a participating Plan, the Guest Membership program would not be an option.

Kaiser Permanente:

There are Kaiser Permanente locations in California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington D.C. You can get most of the same services you would get in your home area when living temporarily in another Kaiser Permanente service area. Find Kaiser facilities at kp.org/locations.

If you're outside our service area or studying abroad, don't worry — you're still covered for emergency care anywhere in the world. However, you're not covered for routine services received from non-Plan providers — like checkups, preventive screenings, and flu shots.

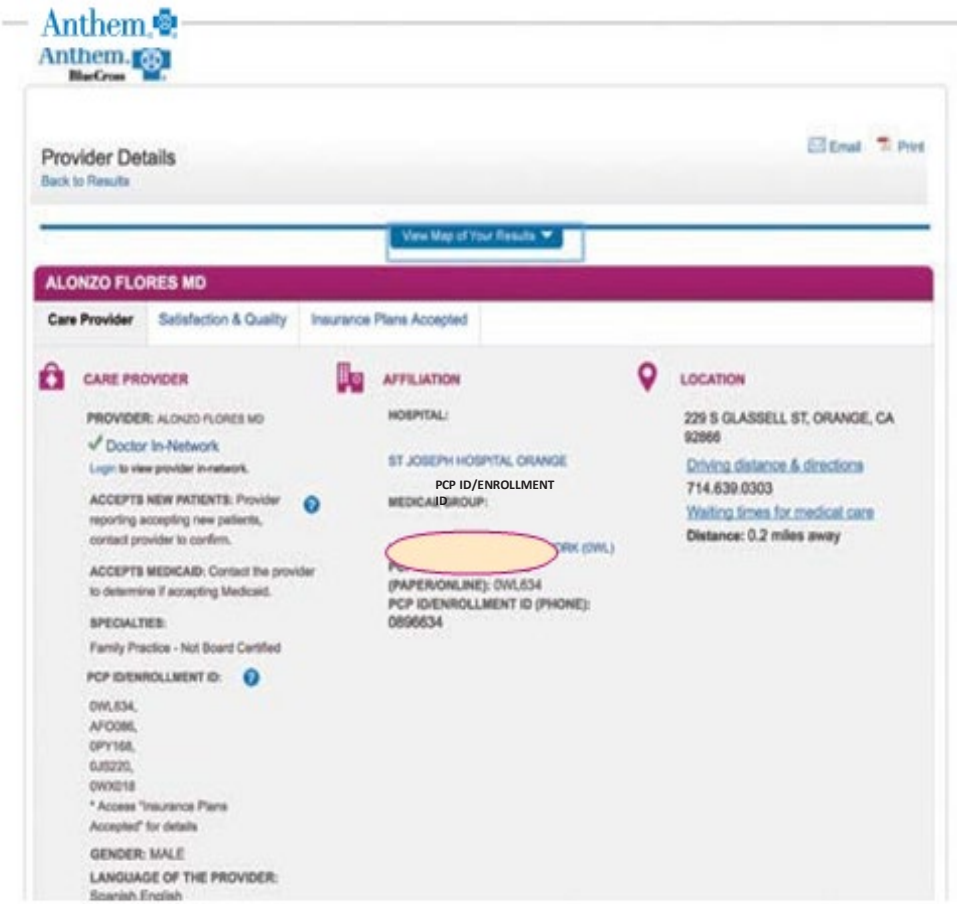
HMO – How to Find a Primary Care Physician and Medical Group

Find a network provider

The Anthem HMO network is one of the largest in California, with more than 110,000 physicians and 387 hospitals

It's easy to find a provider online:

- Go to anthem.com/ca/sisc
- Find Care in the menu selection
- Choose the network you are enrolled in; HMO Full Network (California Care)
- You will then be directed to the Anthem website where you can search by specific provider type or location
- If you're looking for a primary care doctor, select the check boxes that say Accepting New Patients and Able to serve as Primary Care Physician (PCP).
- To find your doctor's provider and medical group/IPA number (needed when you enroll in the HMO plan for the first time), select the doctor's name and look for the online enrollment ID.



The PPO Plans

Key features

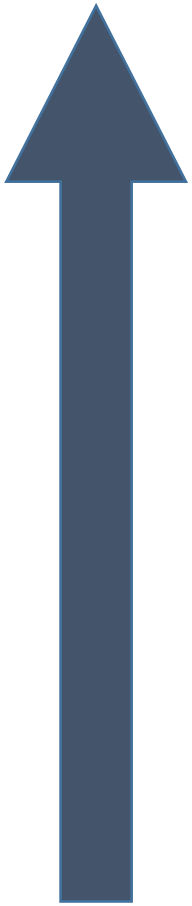
- Access to many in-network doctors
- You don't need a referral to see specialists
- Out of pocket cost can vary based on the provider's fee for service
- Limited coverage for out-of-network providers

Things to consider

- The plan covers most services from almost any doctor or hospital, but you pay less when using a doctor from the **preferred provider organization** (PPO) plan.
- We recommend you visit a contracted/in-network provider for best savings
- Contact Anthem to confirm if services are covered before you visit provider such as labs/urgent care, etc.

Outpatient Arthroscopy, Cataract Surgery, Colonoscopy, Upper GI endoscopy with/without biopsy benefits have a maximum amount paid by Anthem in a hospital setting. Please make sure you contact Anthem before you schedule these procedures.

High Deductible Health Plan (HDHP)



Out-of-Pocket Maximum

Coinsurance

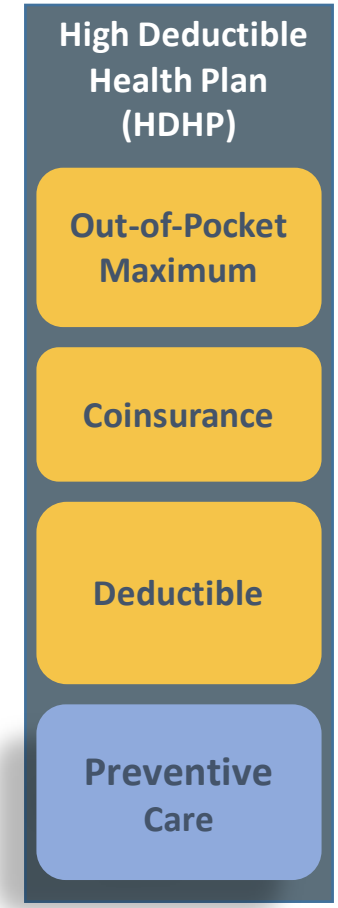
Deductible

Preventive Care

Per the IRS - the out-of-pocket maximum and deductibles will re-set as of January 1st regardless of when the District benefit plan start date is.

Per the IRS code, if you are over the age of 65 and have Medicare part A, B and/or D, you are not qualified for HSA contributions.

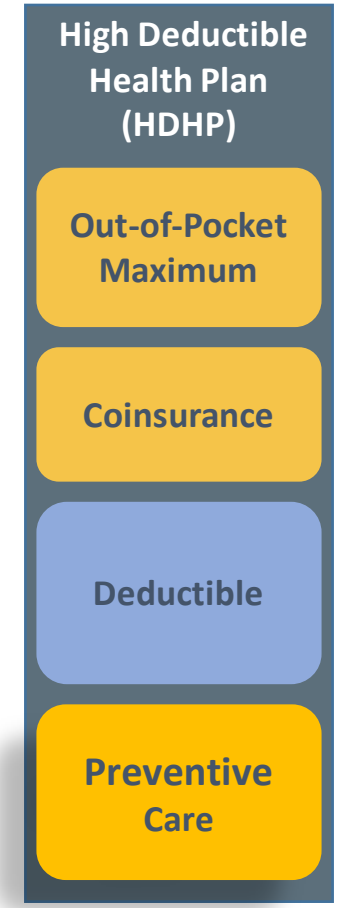
HDHP – Preventative Care



Preventive care 100% covered with in-network providers, includes but not limited to:

- Annual exams, routine prenatal and well-child care, and child and adult immunizations
- Preventive (non-diagnostic) screening services
- Eligible preventive medications

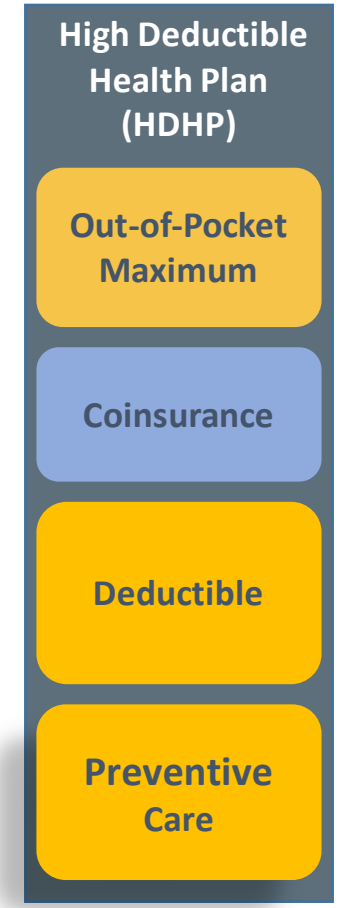
HDHP – Deductible



A specified amount of money that the member must pay before an insurance company will pay a claim:

- The plan summary will note which services are subject to the deductible
- Fee for service information can be obtained from your service provider
- The pharmacy deductible is a part of the medical service deductible

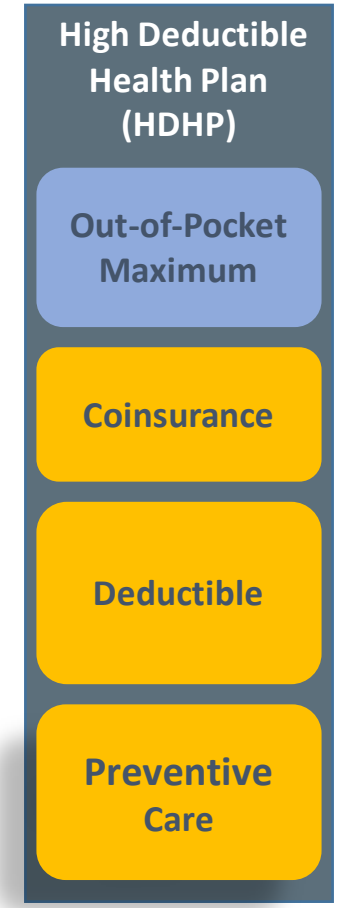
HDHP – Coinsurance



Coinsurance is the percentage of costs a member pays for medical expenses – such as a hospital stay, office visit, medical device, or prescription drug:

- The plan summary will note which services are subject to the coinsurance
- The member will be subject to coinsurance until they have reached their plans out-of-pocket maximum

HDHP – Out-of-Pocket Maximum



This is the maximum amount for medical expenses that the member will be expected to pay out-of-pocket each calendar year:

- The plan summary will note the out-of-pocket maximum
- The out-of-pocket maximum only applies to in-network medical services
- The district plan year runs October through September and the plan out-of-pocket maximum resets every calendar year (a member could possibly be subject to two calendar year out-of-pocket maximums)

Anthem Medical Plans – High-Level Summary

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.

Benefit Information (amounts listed are for in-network services)	Anthem PPO 100A	Anthem PPO 80E	Anthem HMO Full Network
CALENDAR YEAR DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM (OOPM)			
Individual/Family Deductible	$0	$300/$600	$0
Individual/Family Out-of-Pocket Maximums (includes deductible, coinsurance, and co-pays)	$1,000/$3,000	$1,000/$3,000	$2,000/$4,000
PROFESSIONAL SERVICES			
Preventative Care Services (includes physical exams & non-diagnostic screening)	$0 deduct. waived	0% ded. waived	$0
Office Visit/Urgent Care co-pay	$10	$20	$20
Specialist/Consultants co-pay	$10	$20	$40
Prenatal/Postnatal Office Visit co-pay	$10	$20	$20
Scans: CT, CAT, MRI, PET etc.	$0	20%	$100 per test
Diagnostic X-ray & Laboratory Procedures	$0	20%	No charge
HOSPITAL & SKILLED NURSING FACILITY SERVICES			
Emergency Room Visit (co-pay waived if admitted to the hospital)	$100 per visit	$100/visit + 20%	$100 per visit
Inpatient Hospital co-pay (preauthorization required)	$0	20%	$250/admission
Surgery, outpatient – performed in an Ambulatory Surgery Center (hospital outpatient surgery limitations apply)	$0	20%	$125
MENTAL HEALTH SERVICES & SUBSTANCE TREATMENT			
Inpatient Care: Facility based care (preauthorization required)	$0	20%	$250 /admission
Outpatient Care: Physician office visits	$10	$20	$20
OTHER SERVICES			
Acupuncture & Chiropractic (limits apply)	$0	20%	$10/30 visits
Hearing Aids	10%($700/24 mo)	20%($700/24mo)	50%/36 mo
PRESCRIPTION DRUG PLANS			
Pharmacy Out-of-Pocket Maximum	$1500 S/$2500 F	$9/$0 @Costco	$9/$0 @Costco
Generic co-pay/days supply	$5/$0 @ Costco	$35 30 days	$35 30 days
Brand co-pay/days supply & Specialty Drugs (most specialty items)	$20 up to 30 days	$35 30 days	$35 30 days
Mail Order 90 day supply (Generic/Brand co-pay)	$0/$50	$0/$90	$0/$90

Kaiser Medical Plans – High-Level Summary

Per IRS guidelines – Kaiser HDHP/HSA deductible & out-of-pocket maximum will reset to zero as of January 1st regardless of the District benefit plan year.

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.

Benefit Information (amounts listed are for in-network services)	Kaiser HMO Plan	Kaiser HDHP/HSA HMO Plan INDIVIDUAL	2+ COVERED
Employer Annual Health Savings Account (HSA) Contribution [50% funded 10/31 & 50% funded 4/30)	$0	$3,000	$6,000
CALENDAR YEAR DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM (OOPM)			
Individual/Family Deductible	$0	$1,500	$3,000
Individual/Family Out-of-Pocket Maximums (includes deductible, coinsurance, and co-pays)	$1,500/$3,000	$3,000	$6,000
PROFESSIONAL SERVICES			
Preventative Care Services (includes physical exams & non-diagnostic screening)	$0	0% deductible waived	
Office Visit/Urgent Care co-pay	$0	10%	
Specialist/Consultants co-pay	$0	10%	
Prenatal/Postnatal Office Visit co-pay	$0	10%	
Scans: CT, CAT, MRI, PET etc.	$0	10%	
Diagnostic X-ray & Laboratory Procedures	$0	10%	
HOSPITAL & SKILLED NURSING FACILITY SERVICES			
Emergency Room Visit (co-pay waived if admitted to the hospital)	$100 per visit	10%	
Inpatient Hospital co-pay (preauthorization required)	$0	10%	
Surgery, outpatient – performed in an Ambulatory Surgery Center (hospital outpatient surgery limitations apply)	$0	10%	
MENTAL HEALTH SERVICES & SUBSTANCE TREATMENT			
Inpatient Care: Facility based care (preauthorization required)	$0	10%	
Outpatient Care: Physician office visits	$0	10%	
OTHER SERVICES			
Acupuncture & Chiropractic (30 visits combined)	$10	10% Acupuncture/No chiropractic	
Durable Medical Equipment (DME)	$0	10%	
PRESCRIPTION DRUG PLANS			
Generic co-pay/days supply	$5 up to 100 days	$10/30 days after deductible (AD)	
Brand co-pay/days supply	$5 up to 100 days	$30/30 days AD	
Specialty Drugs/days supply	$5 up to 30 days	$30/30 days AD	
Mail Order/day supply (Generic/Brand co-pay)	$5	$20 gen/$60 brand/100 days AD	

Dental, Vision, Life, Disability and EAP Plans

Dental, Vision, Life and EAP Plans Offered by PCCD

2022 – 2023 (Effective October 1, 2022)	
Delta Dental	• DeltaCare HMO • Delta PPO • Delta Incentives
EyeMed Vision	• EyeMed PPO
Voya	• Basic Life • Supplemental life • Long Term Care
Employee Assistance Program	• Anthem EAP (available to all employees) • Voya EAP (available to all employees)

DeltaCare USA Dental Plan – High-Level Summary

DeltaCare USA dental plan is an HMO plan.

How does it work?

- You will need to pick a dentist, or someone will be randomly selected
- You can find a participating primary dentist at www.deltadental.com; Member, Find a Dentist .
- You will receive an ID card with your dentist name. If the dentist name does not match the card, please make sure you contact DeltaCare as soon as possible to make the change before you see the dentist
- You will need to request a referral from your primary dentist for any dental services
- Your and your family members can have different dentists
- Employee will pay a specific copay amount for services (see DeltaCare description of benefits & copayment schedule on the District intranet site

DeltaCare USA does not have an annual plan maximum

Dental Plan Type/Benefits	Delta Dental DHMO In-Network Only
Annual Deductible (Individual / Family)	$0
Waived for Preventive	N/A
Annual Plan Maximum	N/A
Covered Services	
Diagnostic and Preventive Services	Copays vary
Basic Services	Copays vary
Major Services	Copays vary
Crowns and Cast Restorations	Copays vary
Prosthodontics	Copays vary
Orthodontia Services	
Orthodontia 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

This is only a brief summary of benefits. 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.

Delta PPO/Incentive Dental Plans –

High-Level Summary

Dental Plan Type/Benefits	Delta Dental PPO			Delta Dental Incentive (This plan is only available if you were hired at PCCD prior to 1994)		
	PPO Network	Premier Network	Out-of-Network	PPO Network	Premier Network	Out-of-Network
Annual Deductible (Individual / Family)	$0	$25	$25	$0	$0	$0
Waived for Preventive		No		N/A	N/A	N/A
Annual Plan Maximum	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500
Covered Services						
Diagnostic and Preventive Services	100%	90%	90%	70-100%	70-100%	70-100%
Basic Services	90%	70%	70%	70-100%	70-100%	70-100%
Major Services	60%	50%	50%	70-100%	70-100%	70-100%
Crowns and Cast Restorations	60%	50%	50%	70-100%	70-100%	70-100%
Prosthodontics	60%	50%	50%	50%	50%	50%
Orthodontia Services						
Orthodontia Maximum	$1,000 (lifetime maximum)			Not covered		
Adult & Dependent Children	50%	50%	50%	Not covered	Not covered	Not covered

This is only a brief summary of benefits. 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.

EyeMed Vision Plan –
High-Level Summary

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. 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.

Voya Life Plans

PCCD provides full-time eligible employees an $80,000 Basic Term Life and AD&D coverage through VOYA at no cost to you.

Supplemental Life and AD&D coverages are also available for employees and their family members and offered through VOYA. The supplemental benefits are **100% employee paid** through payroll deductions.

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 are based on the age of the employee.

Evidence of insurability (EOI)
Late enrollees must answer health questions for any amount of coverage requested. Current enrollees may increase employee coverage by $10,000 at annual enrollment without EOI; larger amounts require EOI. Child coverage may be elected or increased to the plan maximum of $10,000 without EOI. All other enrollments require EOI with the exception of newly eligible employees.

VOYA offers the following value added benefit to their participants:

- Funeral Services & Online Will Preparation: 800-913-8318 (refer to group number 706540)
- Emergency Travel Assistance Services: 800-859-2821 (refer to contract number 17372020)

The District offers 10thly deduction option for the Supplemental Life/AD&D plans, so make sure you plan appropriately

Disability Income Insurance - VOYA

- Palomar Community College District provides full-time eligible employees with long-term disability income benefits through Voya at no cost to employees.

- 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 Description	Eligibility
Class	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	

Flexible spending account (FSA) Highlights

Lower your taxable income by using a FSA

Pre-tax program for medical and dependent care expenses that is provided through **American Fidelity**

Medical expenses: you can contribute up to $2,850 per year

- Set aside pre-tax dollars for healthcare-related expenses not covered by your health plan.
- Eligible medical expenses include deductibles, coinsurance, copays, dental care, vision care, etc.

Dependent care expenses: you can contribute up to $5,000 per year

<u>You MUST re-enroll each year by</u>:

- Scheduling an online virtual enrollment appointment

The District offers 10thly deduction option for the FSA plans, so make sure you plan appropriately

Employee Assistance Programs (EAP)

EAP program will be offered through Anthem Blue Cross

- This program will be offered to all employees regardless if you are on Anthem, Kaiser or waived coverage
- It is also available to all employee family members living at home
- All calls and services are 100% confidential

This program will offer:

- Telephonic, online or in-person counseling
- Counselors address: marital difficulties, alcohol and drug abuse, family/parenting issues, stress management, grief and loss, depression, and other issues. Referrals are provided for long-term counseling or specialized care
- Web-based tools and resources
- Legal and financial counseling

Contact Anthem EAP
Website: www.anthemEAP.com, enter company code "SISC"
Phone: 800-999-7222

An additional basic EAP program is offered through Voya/ComPsych at no additional cost to employees or family members living at home

Contact Voya EAP
Website: Online: guidanceresources.com
App: GuidanceResources® Now Web ID: My5848i

Hyatt Legal, Aflac and American Fidelity Plans

Hyatt Legal (MetLife Legal)

Life is filled with moments where you might need legal help. From exciting moments like buying a home, to less exciting ones like getting a speeding ticket, Hyatt Legal makes legal help for life's big moments affordable.

Hyatt Legal Plans, gives you access to a nationwide network of more than 2,500 law firms whose members (plan attorneys) will provide complete representation on a **variety** of legal matters, including: Selling, purchasing, or refinancing a home. Wills, living trusts, name changes, and premarital agreements.

Hyatt Legal is **100% employee paid** through payroll deductions.

10thly cost is $23.40

Limited Benefit
Accident Only Insurance

24-Hour Coverage

Sport-Related Injury

Wellness Benefit

Over 25 Treatments Covered

americanfidelity.com/info/accident

This product may contain limitations, exclusions, and waiting periods.
This product is inappropriate for people who are eligible for Medicaid coverage. Wellness not available in all states.

AMERICAN FIDELITY
a different opinion

Limited Benefit Cancer Insurance

Transportation and Lodging Expenses

Multiple Coverage Options

Diagnostic and Prevention Testing

More than 25 Benefits

americanfidelity.com/info/cancer

This product may contain limitations, exclusions, and waiting periods.
This product is inappropriate for people who are eligible for Medicaid coverage.

AMERICAN FIDELITY
a different opinion

Disability Income Insurance

Guaranteed Issue

Custom Coverage Options

Return-to-Work Benefit

Employee Assistance Program

americanfidelity.com/info/disability

This product may contain limitations, exclusions, and waiting periods.

AMERICAN FIDELITY
a different opinion

Limited Benefit Critical Illness Insurance

Simplified Underwriting

Health Screening

Lump Sum Benefit

Recurrent Diagnosis Benefit

americanfidelity.com/info/critical-illness

This product may contain limitations, exclusions, and waiting periods.
This product is inappropriate for people who are eligible for Medicaid coverage.

AMERICAN FIDELITY
a different opinion

Life Insurance Options

- AF™ **Term Life Insurance**
- AF™ **Whole Life Insurance**
- Universal Life Insurance

americanfidelity.com/info/life

AF™ Whole Life Insurance and AF™ Term Life Insurance: This product may contain limitations, exclusions, and waiting periods. Not generally qualified benefits under Section 125 Plans.
Universal Life Insurance: This product may contain limitations, exclusions, and waiting periods. Not generally qualified benefits under Section 125 Plans. After the guaranteed period, the premiums may change. Underwritten by Texas Life Insurance Company. Not affiliated with American Fidelity Assurance Company.

AMERICAN FIDELITY
a different opinion

Get help with expenses health insurance doesn't cover

Product features

- Individual policies are **guaranteed renewable.**
- Benefits on individual policies are **paid directly to policyholders**, unless otherwise assigned.
- Coverage is **portable.**
- Historical **rate stability.**

Aflac®

Accident

Accidents happen. When a covered accident happens to you, our accident insurance policy pays you cash benefits (unless assigned) to help with the unexpected medical and everyday expenses that can begin to add up almost immediately.

Critical illness

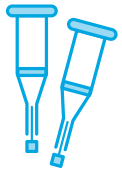
Serious illnesses such as a heart attack or stroke can have an impact on your financial health. Aflac's Lump Sum Critical Illness insurance can help provide peace of mind if you experience a covered health event.

Hospital Indemnity

Even a quick trip to the emergency room can result in costly medical bills that health insurance may not cover leaving you with out-of-pocket expenses. That's where Aflac can help.

Cancer/ Specified-disease

Coverage when you really need it. Our Cancer Protection Assurance insurance policies help cover innovative treatments with benefits that care for you as a whole person. Learn how Aflac benefits can help.



Short-term disability

Illnesses or injuries that keep you from working make it difficult to pay your bills. If you experience a covered disability, Aflac's short-term disability coverage helps provide you with a source of income that can allow you to focus on getting better, instead of on your finances.

Aflac®

Ready to take the next step to protect your future?

Aflac uses Everwell™ to accept applications over the phone & online. Please schedule a 1 on 1 session with your agent after today's meeting.

Your agent will be available by phone or virtual appointment to answer questions & help you complete the steps to apply for the Aflac insurance policies you choose.

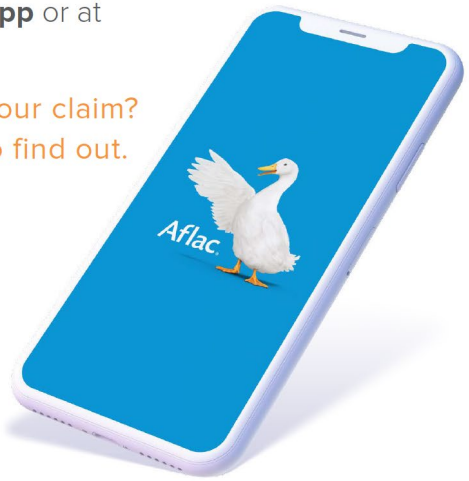
Aflac

Getting paid is as easy as 1-2-3 with Aflac

1. Visit aflac.com/myaflac or download the **MyAflac mobile app** to register and log in to your account. If you choose not to register, you can file a claim as a guest.
2. **Enroll in claims direct deposit**[1] and file an online claim to get paid quickly.
3. **File your claim** online at aflac.com/myaflac or on the **MyAflac mobile app**. You may file up to 20 claims within a 24-hour period, and submit claims as far back as 10 years.

Track the status of your claim in the My Claims section on the **MyAflac℠ mobile app** or at **aflac.com/myaflac.**

Not sure what you need to file your claim? Go to **aflac.com/myresources** to find out.



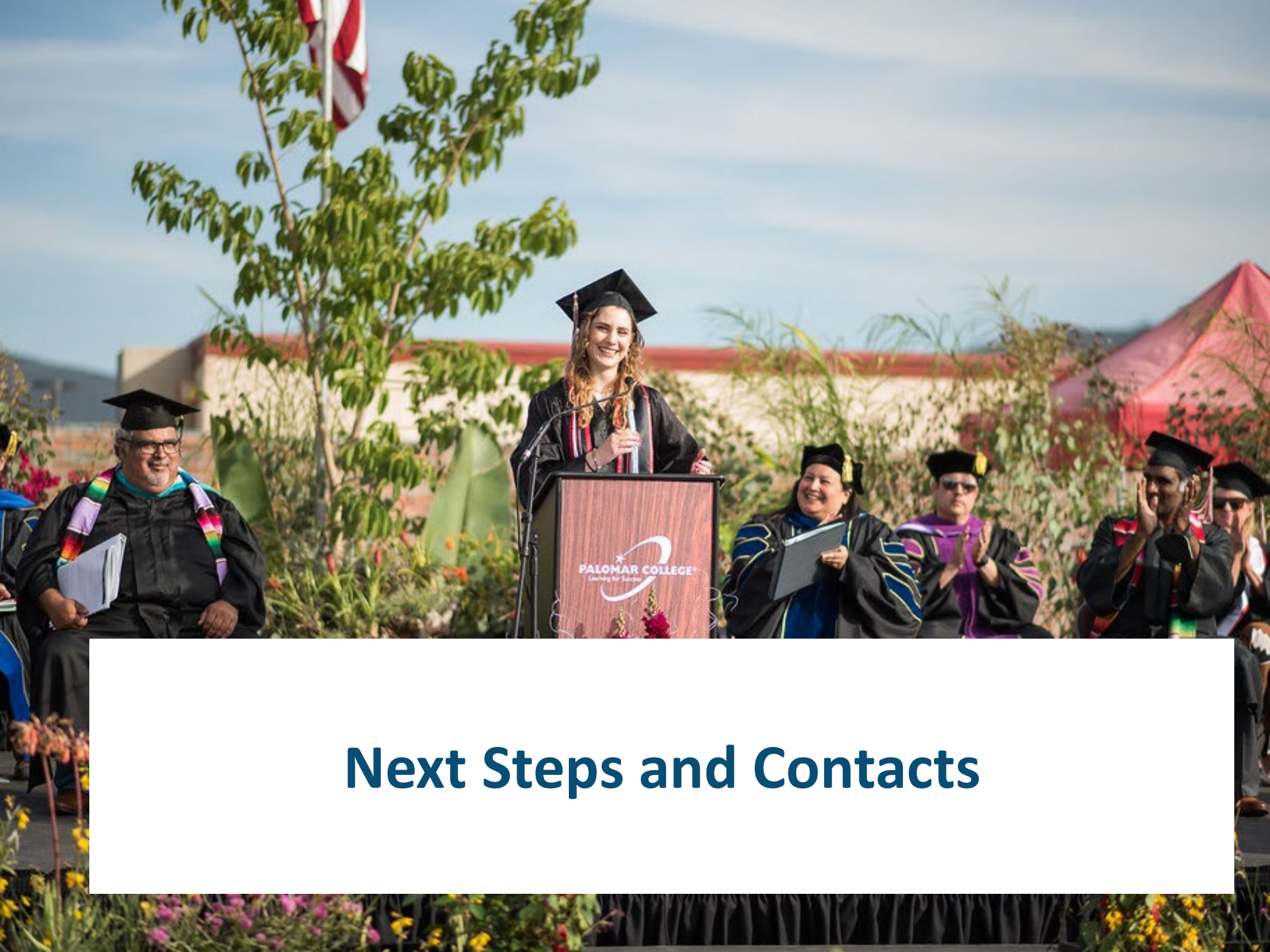
Download on the App Store

GET IT ON Google Play

Need help filling claims?

Thank you

Jill Krenkler
760-473-8023
jill_krenkler@us.aflac.com



Next Steps and Contacts

Next Steps

Open Enrollment Information

You will enroll online with the eBenefits information below during the month of August. The effective date of your selection will be October 1st. Your username and login for the eBenefits online platform will reset effective August 1, 2022.

No paper forms for this Open Enrollment, all changes must be made online in the eBenefits system.

All Domestic Partnerships are required to be registered with the state.

To enroll via eBenefits secure portal:

Go to https://www2.palomar.edu/pages/hr/employees/openenrollment/ Scroll down to "eBenefits Online Benefit Election Portal"

- Click on the Create a NEW login for this year link
- You will be asked for your last name, date of birth and last four of your social security number
- Follow the system prompts to create a username and password
- If you are having any problems login to the system, contact Ebenefits at (866) 203-8051 Monday through Friday from 4 am – 7 pm or Saturday from 5 am – 12 PM PST

What Will Happen if I Don't Enroll in Benefits

If you do not re-enroll in the medical/dental/vision/life plans:

- Your plan coverage(s) will continue as-is.

Everyone must re-enroll in the Flexible Spending Account(s); FSA/DCA plans:

- If you do not re-enroll you will not have coverage as of 10/1/22. The IRS requires all participants to re-enroll annually in these plans; no exceptions.

Anthem 100A PPO plans, new deductions will reflect on the end of October paycheck.

Next Steps (continued)

Additional Information
Emails will be sent to employees during August with open enrollment information, links, and vendor information.
Update your address by completing the digital address/name change form
Review materials and resources on the Palomar Open Enrollment webpage

In-Person & Zoom Benefit Meeting Dates

Open Enrollment Zoom Link: https://palomar-edu.zoom.us/j/91601698750

Dates	Times
Monday, August 1,2022	Open Enrollment Start
~~Wednesday, August 3, 2022~~	~~Benefits Drop-in Hours1:00pm to 3:00pm~~
Thursday, August 11, 2022	Benefits Drop-in Hours 9:00am to 11:00am (LRC 208)
Monday, August 15, 2022	Benefits Drop-in Hours 2:00pm to 4:00pm (LRC 438)
Thursday, August 18, 2022	Costco Flu Shots MD 157 9:00am to 2:00pm (sign up in the PD portal)
	Financial Wellness Workshop 9:00am **(sign up in the PD portal)**
	Anthem EAP Overview 10:30am to 12:00pm **(sign up in the PD portal)**
	Open Enrollment Workshop 12:30pm **(sign up in the PD portal)**
Friday, August 26, 2022	Benefits Drop-in Hours 8:00am to 10:00am (LRC 208)
Tuesday, August 30, 2022	Benefits Drop-in Hours 2:00pm to 4:00pm (LRC 208)
Wednesday, August 31, 2022	Open Enrollment Closes

Individuals requiring sign-language Interpreters, real-time captioners, or other accommodations should contact the Benefits Department at (760) 744-1150, et. 3053 or benefits@palomar.edu two weeks in advance of the event or five days in advance for a workshop. Visit the Human Resource Services Benefits for the online Interpreting/Captioning Request Form or access it here Accessibility Services – Human Resource Services (palomar.edu)

Questions?
Please direct questions regarding employee benefits to:

benefits@palomar.edu

Resources

Palomar Community College District Benefit Department

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

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

Premium Assistance Under Medicaid and theChildren's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

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

GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Asistencia con las primas bajo Medicaid y el Programa de Seguro de Salud para Menores (CHIP)

Si usted o sus hijos son elegibles para Medicaid o CHIP y usted es elegible para cobertura médica de su empleador, su estado puede tener un programa de asistencia con las primas que puede ayudar a pagar por la cobertura, utilizando fondos de sus programas Medicaid o CHIP. Si usted o sus hijos no son elegibles para Medicaid o CHIP, usted no será elegible para estos programas de asistencia con las primas, pero es probable que pueda comprar cobertura de seguro individual a través del mercado de seguros médicos. Para obtener más información, visite **www.cuidadodesalud.gov**.

Si usted o sus dependientes ya están inscritos en Medicaid o CHIP y usted vive en uno de los estados enumerados a continuación, comuníquese con la oficina de Medicaid o CHIP de su estado para saber si hay asistencia con primas disponible.

Si usted o sus dependientes NO están inscritos actualmente en Medicaid o CHIP, y usted cree que usted o cualquiera de sus dependientes puede ser elegible para cualquiera de estos programas, comuníquese con la oficina de Medicaid o CHIP de su estado, llame al **1-877-KIDS NOW** o visite **espanol.insurekidsnow.gov/** para información sobre como presentar su solicitud. Si usted es elegible, pregunte a su estado si tiene un programa que pueda ayudarle a pagar las primas de un plan patrocinado por el empleador.

Si usted o sus dependientes son elegibles para asistencia con primas bajo Medicaid o CHIP, y también son elegibles bajo el plan de su empleador, su empleador debe permitirle inscribirse en el plan de su empleador, si usted aún no está inscrito. Esto se llama oportunidad de "inscripción especial", y **usted debe solicitar la cobertura dentro de los 60 días de haberse determinado que usted es elegible para la asistencia con las primas**. Si tiene preguntas sobre la inscripción en el plan de su empleador, comuníquese con el Departamento del Trabajo electrónicamente a través de **www.askebsa.dol.gov** o llame al servicio telefónico gratuito **1-866-444-EBSA (3272)**.

Si usted vive en uno de los siguientes estados, tal vez sea elegible para asistencia para pagar las primas del plan de salud de su empleador. La siguiente es una lista de estados actualizada al 31 de enero de 2022. Comuníquese con su estado para obtener más información sobre la elegibilidad -

ALABAMA – Medicaid	ARKANSAS – Medicaid
Sitio web: http://myalhipp.com Teléfono: 1-855-692-5447	Sitio web: http://myarhipp.com/ Teléfono: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**CALIFORNIA – Medicaid**
El Programa de Pago de Alaska primas del seguro médico Sitio web: http://myakhipp.com Teléfono: 1-866-251-4861 Por correo electrónico: CustomerService@MyAKHIPP.com Elegibilidad de Medicaid: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Sitio web: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Teléfono: 916-445-8322 Fax: 916-440-5676 Por correo electrónico: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Programa Medicaid de Colorado) y Child Health Plan Plus (CHP+)	IOWA – Medicaid y CHIP (Hawki)
Sitio web de Health First Colorado: https://www.healthfirstcolorado.com/es Centro de atención al cliente de Health First Colorado: 1-800-221-3943/ retransmisor del estado: 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Atención al cliente de CHP+: 1-800-359-1991/ retransmisor del estado: 711 Programa de compra de seguro de salud (HIBI, por sus siglas en inglés): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program Atención al cliente de HIBI: 1-855-692-6442	Sitio web de Medicaid: https://dhs.iowa.gov/ime/members Teléfono de Medicaid: 1-800-338-8366 Sitio web de Hawki: http://dhs.iowa.gov/Hawki Teléfono de Hawki: 1-800-257-8563 Sitio web de HIPP; https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Teléfono de HIPAA: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Sitio web: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Teléfono: 1-877-357-3268	Sitio web: https://www.kancare.ks.gov/ Teléfono: 1-800-792-4884
GEORGIA – Medicaid	**KENTUCKY – Medicaid**
Sitio web de GA HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Teléfono: 678-564-1162, Presiona 1 Sitio web de GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Teléfono: (678) 564-1162, Presiona 2	Sitio web del Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Teléfono: 1-855-459-6328 Por correo electrónico: KIHIPP.PROGRAM@ky.gov Sitio web de KCHIP: https://kidshealth.ky.gov/es/Pages/default.aspx Teléfono: 1-877-524-4718 Sitio web de Medicaid de Kentucky: https://chfs.ky.gov/Pages/spanish.aspx
INDIANA - Medicaid	**LOUISIANA – Medicaid**
Healthy Indiana Plan para adultos de bajos ingresos 19-64 Sitio web: http://www.in.gov/fssa/hip/ Teléfono: 1-877-438-4479 Todos los demás Medicaid Sitio web: https://www.in.gov/medicaid/ Telefono: 1-800-457-4584	Sitio web: www.medicaid.la.gov o www.ldh.la.gov/lahipp Teléfono: 1-888-342-6207 (línea directa de Medicaid) o 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	NUEVA JERSEY – Medicaid y CHIP
Sitio web por inscripción: http://www.maine.gov/dhhs/ofi/applications-forms Teléfono: 1-800-442-6003 TTY: Maine relay 711 Página Web por primos de seguro de salud privado: https://www.maine.gov/dhhs/ofi/applications-forms Teléfono: 1-800-977-6740 TTY: Maine relay 711	Sitio web de Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Teléfono de Medicaid: 609-631-2392 Sitio web de CHIP: http://www.njfamilycare.org/index.html Teléfono de CHIP: 1-800-701-0710
MASSACHUSETTS – Medicaid y CHIP	**NUEVA YORK – Medicaid**
Sitio web: https://www.mass.gov/masshealth/pa Teléfono: 1-800-862-4840	Sitio web: https://www.health.ny.gov/health_care/medicaid/ Teléfono: 1-800-541-2831
MINNESOTA – Medicaid	**CAROLINA DEL NORTE – Medicaid**
Sitio web: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Teléfono: 1-800-657-3739	Sitio web: https://medicaid.ncdhhs.gov Teléfono: 919-855-4100
MISSOURI – Medicaid	**DAKOTA DEL NORTE – Medicaid**
Sitio web: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Teléfono: 573-751-2005	Sitio web: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Teléfono: 1-844-854-4825
MONTANA – Medicaid	**CAROLINA DEL SUR – Medicaid**
Sitio web: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Teléfono: 1-800-694-3084	Sitio web: https://www.scdhhs.gov Teléfono: 1-888-549-0820
NEBRASKA – Medicaid	**DAKOTA DEL SUR – Medicaid**
Sitio web: http://www.ACCESSNebraska.ne.gov Teléfono: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Sitio web: https://dss.sd.gov Teléfono: 1-888-828-0059
NEVADA – Medicaid	**OKLAHOMA – Medicaid y CHIP**
Sitio web de Medicaid: http://dhcfp.nv.gov Teléfono de Medicaid: 1-800-992-0900	Sitio web: http://www.insureoklahoma.org Teléfono: 1-888-365-3742
NUEVO HAMPSHIRE – Medicaid	**OREGON – Medicaid**
Sitio web: https://www.dhhs.nh.gov/oii/hipp.htm Teléfono: 603-271-5218 Teléfono gratuito para el programa de HIPP: 1-800-852-3345, ext. 5218	Sitio web: https://healthcare.oregon.gov/Pages/index.aspx http://oregonhealthcare.gov/index-es.html Teléfono: 1-800-699-9075

PENSILVANIA – Medicaid	VIRGINIA – Medicaid y CHIP
Sitio web: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Teléfono: 1-800-692-7462	Sitio web: https://www.coverva.org/es/famis-select https://www.coverva.org/es/hipp Teléfono de Medicaid: 1-800-432-5924 Teléfono de CHIP: 1-800-432-5924
RHODE ISLAND – Medicaid y CHIP	**WASHINGTON – Medicaid**
Sitio web: http://www.eohhs.ri.gov Teléfono: 1-855-697-4347 o 401-462-0311 (Direct RIte Share Line)	Sitio web: http://www.hca.wa.gov Teléfono: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Sitio web: http://pontehipptexas.com/ Teléfono: 1-800-440-0493	Sitio web: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Teléfono de Medicaid: 304-558-1700 Teléfono gratuito: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid y CHIP	**WISCONSIN – Medicaid y CHIP**
Sitio web de Medicaid: https://medicaid.utah.gov/spanish-language Sitio web de CHIP: https://chip.health.utah.gov/espanol/ Teléfono: 1-877-543-7669	Sitio web: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Teléfono: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Sitio web: http://www.greenmountaincare.org/ Teléfono: 1-800-250-8427	Sitio web: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Teléfono: 1-800-251-1269

Para saber si otros estados han agregado el programa de asistencia con primas desde el 31 de enero de 2022, o para obtener más información sobre derechos de inscripción especial, comuníquese con alguno de los siguientes:

Departamento del Trabajo de EE.UU.
Administración de Seguridad de Beneficios de los Empleados
www.dol.gov/agencies/ebsa/es/about-ebsa/our-activities/informacion-en-espanol
1-866-444-EBSA (3272)

Departamento de Salud y Servicios Humanos de EE.UU.
Centros para Servicios de Medicare y Medicaid
www.cms.hhs.gov
1-877-267-2323, opción de menú 4, Ext. 61565

Declaración de la Ley de Reducción de Trámites

Según la Ley de Reducción de Trámites de 1995 (Ley Pública 104-13) (PRA, por sus siglas en inglés), no es obligatorio que ninguna persona responda a una recopilación de información, a menos que dicha recopilación tenga un número de control válido de la Oficina de Administración y Presupuesto (OMB, por sus siglas en inglés). El Departamento advierte que una agencia federal no puede llevar a cabo ni patrocinar una recopilación de información, a menos que la OMB la apruebe en virtud de la ley PRA y esta tenga un número de control actualmente válido de la oficina mencionada. El público no tiene la obligación de responder a una recopilación de información, a menos que esta tenga un número de control actualmente válido de la OMB. Consulte la Sección 3507 del Título 44 del Código de Estados Unidos (USC). Además, sin perjuicio de ninguna otra disposición legal, ninguna persona quedará sujeta a sanciones por no cumplir con una recopilación de información, si dicha recopilación no tiene un número de control actualmente válido de la OMB. Consulte la Sección 3512 del Título 44 del Código de Estados Unidos (USC).

Se estima que el tiempo necesario para realizar esta recopilación de información es, en promedio, de aproximadamente siete minutos por persona. Se anima a los interesados a que envíen sus comentarios con respecto al tiempo estimado o a cualquier otro aspecto de esta recopilación de información, como sugerencias para reducir este tiempo, a la dependencia correspondiente del Ministerio de Trabajo de EE. UU., a la siguiente dirección: U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210. También pueden enviar un correo electrónico a ebsa.opr@dol.gov y hacer referencia al número de control de la OMB 1210-0137.

Número de Control de OMB 1210-0137 (vence al 31 de enero de 2023)

General Notice of COBRA Continuation Coverage Rights
** Continuation 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.

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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Palomar Community College District, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- 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: Palomar College Benefits Office (benefits@palomar.edu)**.**

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. The insurance will require certification, from a health provider, of the disability.

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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.

Plan contact information

Palomar Community College District Benefits Office. Veronica Sadowski, Benefits Technician, 1140 West Mission Road, San Marcos, CA 92069, benefits@palomar.edu (760)744-1150 X-3053.

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HUMAN RESOURCE SERVICES

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).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Palomar Community College District	95-6002227
5. Employer address	**6. Employer phone number**
1140 West Mission Road	760-744-1150 x-3053

7. City	8. State	9. ZIP code
San Marcos	CA	92069

10. Who can we contact about employee health coverage at this job?
Veronica Sadowski

11. Phone number (if different from above)	12. Email address
760-744-1150 x-3053	benefits@palomar.edu

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

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

[x] All employees. Eligible employees are:

Permanent Classified and Management employees working a minimum of 20 hours per week, and a minimum of 30 hours per week for Faculty employees

[ ] Some employees. Eligible employees are:

- With respect to dependents:

[x] We do offer coverage. Eligible dependents are:

Legal spouse, registered domestic partner, dependent children to age 26, and disabled adult children above the age of 26

[ ] We do not offer coverage.

[x] 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.

Nuevas opciones de cobertura en el mercado de seguros médicos y su cobertura médica

Formulario aprobado
OMB N.° 1210-0149
(caduca el 30-6-2023)

PARTE A: Información general

Cuando entren en vigencia las partes clave de la ley de salud en el 2014, habrá una nueva forma de adquirir seguros médicos: a través del mercado de seguros médicos. A fin de ayudarle mientras evalua las opciones para usted y su familia, este aviso brinda información básica sobre el nuevo mercado y la cobertura médica basada en el empleo que brinda su empleador.

¿Qué es el mercado de seguros médicos?

El mercado está diseñado para ayudarle a encontrar un seguro médico que satisfaga sus necesidades y se ajuste a su presupuesto. El mercado ofrece opciones de compra en un solo sitio, para buscar y comparar opciones de seguros médicos privados. También es posible que sea elegible para un nuevo tipo de crédito tributario que reduce su prima mensual de inmediato. El periodo de inscripción para la cobertura de seguro médico a través del mercado comienza en octubre del 2013 para la cobertura que comienza el 1.º de enero del 2014.

¿Puedo ahorrar dinero en las primas del seguro médico que ofrece el mercado?

Es posible que tenga la oportunidad de ahorrar dinero y reducir su prima mensual, pero solo si su empleador no ofrece cobertura médica u ofrece una cobertura que no cumple con determinadas normas. Los ahorros en la prima por la cual puede ser elegible dependen de los ingresos de su familia.

¿La cobertura médica del empleador afecta la elegibilidad para los ahorros en la prima a través del mercado?

Sí. Si su empleador brinda cobertura médica que cumple con determinadas normas, no será elegible para un crédito tributario a través del mercado y es possible que desee inscribirse en el plan de salud de su empleador. No obstante, es posible que sea elegible para un crédito tributario que reduce la prima mensual o para una reducción en la cuota de los costos si su empleador no brinda cobertura o no brinda cobertura que cumple con determinadas normas. Si el costo del plan de su empleador que le brindaría cobertura a usted (y no, a los demás miembros de la familia) supera el 9.5 % del ingreso anual de su familia, o si la cobertura médica que brinda su empleador no cumple con la norma de "valor mínimo" establecida por la Ley del Cuidado de Salud a Bajo Precio (Affordable Care Act o ACA, por sus siglas en inglés), es posible que sea elegible para un crédito tributario.[1]

Nota: Si adquiere un plan de salud a través del mercado en lugar de aceptar la cobertura médica que brinda su empleador, es posible que pierda las contribuciones (si las hay) que el empleador da para la cobertura médica que brinda. Además, las contribuciones del empleador (así como sus las contributions como empleado para la cobertura médica que brinda el empleador) a menudo se excluyen del ingreso sujeto impuesto federal y estatal. Los pagos para la cobertura médica a través del mercado se realizan después de impuestos.

¿Cómo puedo obtener más información?

Para obtener más información sobre la cobertura que brinda el empleador, consulte el resumen de la descripción del Plan o comuníquese con _____.

El mercado puede ayudarlo a evaluar sus opciones de cobertura, incluida su elegibilidad para la cobertura a través del mercado y sus costos. Visite CuidadoDeSalud.gov para obtener más información, incluida una solicitud en línea de cobertura de seguros médicos e información de contacto para un mercado de seguros médicos en su área.

[1] Un plan de salud patrocinado por el empleador cumple con la "norma de valor mínimo" si la participación del plan en los costos totales de beneficios permitidos cubiertos por el plan no es inferior al 60 por ciento de dichos costos.

PARTE B: Información sobre la cobertura médica que brinda su empleador

Esta sección incluye información sobre la cobertura médica que brinda su empleador. Si decide completar una solicitud de cobertura médica en el mercado, deberá brindar esta información. Esta información está enumerada de forma tal que coincida con la solicitud del mercado.

3. Nombre del empleador	4. Número de identificación del empleador (EIN, por sus siglas en inglés)
Palomar Community College District	95-6002227
5. Dirección del empleador	**6. Número de teléfono del empleador**
1140 West Mission Road	760-744-1150 x-3053

7. Ciudad	8. Estado	9. Código postal
San Marcos	CA	92069

10. ¿Con quién podemos comunicarnos en relación con la cobertura médica del empleado en este empleo?	
Veronica Sadowski. Benefits Technician	
11. Número de teléfono (si difiere del que figura arriba)	**12. Dirección de correo electrónico**
760-744-1150 x-3053	benefits@palomar.edu

A continuación, encontrará información básica sobre la cobertura médica que brinda este empleador:

- Como su empleador, ofrecemos un plan de salud para los siguientes:

  [x] Todos los empleados.
  [ ] Algunos empleados. Los empleados elegibles son los siguientes:

  Permanent Classified and Management employees working a mínimum of 20 hours per week, and 30 hours per week for Faculty employees

- En cuanto a los dependientes:

  [x] Sí ofrecemos cobertura médica. Los dependientes elegibles son los siguientes:

  Legal spouse, registered domestic partner, children to the age of 26, and adult disabled children over the age of 26

  [ ] No ofrecemos cobertura médica.

[x] Si marca esta opción, esta cobertura médica cumple con la norma de valor mínimo. Asimismo, el costo de la cobertura se pretende que sea asequible para usted según los salarios de los empleados.

** Incluso si el objetivo de su empleador es brindarle cobertura asequible, es posible que sea elegible para obtener un descuento en la prima a través del mercado. El mercado utilizará el ingreso de su grupo familiar, junto con otros factores, para determinar si es elegible para recibir un descuento en la prima. Si, por ejemplo, sus salarios varían de una semana a la otra (tal vez es un empleado por hora o trabaja con comisiones), si fue contratado recientemente a mitad de año o si tiene otras pérdidas de ingreso, aún así es posible que reúna los requisitos para recibir un descuento en la prima.

Si decide adquirir cobertura a través del mercado, visite CuidadoDeSalud.gov para obtener instrucciones sobre cómo hacerlo. Aquí encontrará la información del empleador que debe ingresar cuando visita CuidadoDeSalud.gov para saber si puede obtener un crédito tributario para reducir las primas mensuales.

Important Notice from Palomar 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 Palomar 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. **Palomar Community College District has determined that the prescription drug coverage offered by the SISC Program is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Palomar Community College District coverage will be affected.

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

If you do decide to join a Medicare drug plan and drop your current Palomar Community College District coverage, be aware that you and your dependents will not be able to get this coverage back.

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 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 Veronica Sadowski 760-744-1150 X-3053 or benefits@palomar.edu. **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 [Insert Name of Entity] 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 www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-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).

[Optional Insert - Entities can choose to insert the following information box if they choose to provide a personalized disclosure notice.]

Medicare Eligible Individual's Name: [Insert Full Name of Medicare Eligible Individual]
Individual's DOB or unique Member ID: [Insert Individual's Date of Birth], or [Member ID]

The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:

From: [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]
From: [Insert MM/DD/YY] **To:** [Insert MM/DD/YY]

Date: [Insert MM/DD/YY]
Name of Entity/Sender: [Insert Name of Entity]

Contact--Position/Office:	[Insert Position/Office]
Address:	[Insert Street Address, City, State & Zip Code of Entity]
Phone Number:	[Insert Entity Phone Number]

Aviso Importante de Palomar Community College District Sobre su Cobertura para Recetas Médicas y Medicare

Por favor lea este aviso cuidadosamente y guárdelo donde pueda encontrarlo. Este aviso contiene información sobre su cobertura actual para recetas médicas con Palomar Community College District y sus opciones bajo la cobertura de Medicare para medicamentos recetados . Además, le menciona dónde encontrar más información que le ayude a tomar decisiones sobre su cobertura para medicinas. Si usted está considerando inscribirse, debe comparar su cobertura actual, incluyendo los medicamentos que están cubiertos a qué costo, con la cobertura y los costos de los planes que ofrecen cobertura de medicinas recetadas en su área. Información sobre dónde puede obtener ayuda para tomar decisiones sobre su cobertura de medicamentos recetados se encuentra al final de este aviso.

Hay dos cosas importantes que usted necesita saber sobre su cobertura actual de Medicare y la cobertura de medicamentos recetados:

1. **La nueva cobertura de Medicare para recetas médicas está disponible desde el 2006 para todas las personas con Medicare. Usted puede obtener esta cobertura si se inscribe en un Plan de Medicare para Recetas Médicas, o un Plan Medicare Advantage (como un PPO o HMO) que ofrece cobertura para medicamentos recetados. Todos los planes de Medicare para recetas médicas proporcionan por lo menos un nivel estándar de cobertura establecido por Medicare. Además, algunos planes pueden ofrecer más cobertura por una prima mensual más alta.**

2. **Palomar Community College District ha determinado que la cobertura para recetas médicas ofrecida por el SISC Plans en promedio se espera que pague tanto como lo hará la cobertura estándar de Medicare para recetas médicas para todos los participantes del plan y por lo tanto es considerada Cobertura Acreditable. Debido a que su cobertura actual es Acreditable, usted puede mantener esta cobertura y no pagar una prima más alta (una penalidad), si más tarde decide inscribirse en un plan de Medicare.**

¿Cuándo puede inscribirse en un plan de Medicare de medicamentos?

Usted puede inscribirse en un plan de Medicare de medicamentos la primera vez que es elegible para Medicare y cada año del 15 de octubre al 7 de diciembre.

Sin embargo, si pierde su cobertura actual acreditable, y no es su culpa, usted será elegible para dos (2) meses en el Período de Inscripción Especial (SEP) para subscribirse en un Plan Medicare de medicinas.

¿Qué sucede con su cobertura actual si decide inscribirse en un plan de Medicare de medicamentos?

Si decide inscribirse en un plan de Medicare de medicamentos recetados, su cobertura actual con Palomar Community College District no puede ser afectada.

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

Si cancela su cobertura actual con Palomar Community College District y se inscribe en un plan de Medicare para recetas médicas, puede ser que más adelante ni usted ni sus dependientes no puedan obtener su cobertura de nuevo.

¿Cuándo usted pagará una prima más alta (penalidad) para inscribirse en un plan de Medicare de medicamentos?

Usted debe saber también que si cancela o pierde su cobertura actual con Palomar Community College District y deja de inscribirse en una cobertura de Medicare para recetas médicas después de que su cobertura actual termine, podría pagar más (una penalidad) por inscribirse más tarde en una cobertura de Medicare para recetas médicas.

Si usted lleva 63 días o más sin cobertura acreditable para recetas médicas que sea por lo menos tan buena como la cobertura de Medicare para recetas médicas, su prima mensual aumentará por lo menos un 1% al mes por cada mes que usted no tuvo esa cobertura. Por ejemplo, si usted lleva diecinueve meses sin cobertura acreditable, su prima siempre será por lo menos 19% más alta de lo que la mayoría de la gente paga. Usted tendrá que pagar esta prima más alta (penalidad) mientras tenga la cobertura de Medicare. Además, usted tendrá que esperar hasta el siguiente mes de octubre para inscribirse.

Para más información sobre este aviso o su cobertura actual para recetas médicas…

Llame a nuestra oficina para más información Veronica Sadowski 760-744-1150 x-3053 o benefits@palomar.edu . **NOTA:** Usted recibirá este aviso cada año. Recibirá el aviso antes del próximo período en el cual usted puede inscribirse en la cobertura de Medicare para recetas médicas, y en caso de que esta cobertura con Palomar Community College District cambie. Además, usted puede solicitar una copia de este aviso en cualquier momento.

Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas…

Revise el manual "Medicare y Usted" para información más detallada sobre los planes de Medicare que ofrecen cobertura para recetas médicas. Medicare le enviará por correo un ejemplar del manual. Tal vez los planes de Medicare para recetas médicas le llamen directamente. Asimismo, usted puede obtener más información sobre los planes de Medicare para recetas médicas de los siguientes lugares:

- Visite www.medicare.gov por Internet para obtener ayuda personalizada,
- Llame a su Programa Estatal de Asistencia sobre Seguros de Salud (consulte su manual Medicare y Usted para obtener los números telefónicos)
- Llame GRATIS al 1-800-MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben llamar al 1-877-486-2048.

Para las personas con ingresos y recursos limitados, hay ayuda adicional que paga por un plan de Medicare para recetas médicas. El Seguro Social (SSA, por sus siglas en inglés) tiene disponible información sobre esta ayuda adicional. Para más información sobre esta ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778.

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HUMAN RESOURCE SERVICES

Newborns' Act Disclosure

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).

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Patient Protection Disclosure

Anthem Full Network HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the Palomar Community College Benefits Office designates one for you based on your home zip code. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Palomar Community College District Benefits Office at 760-744-1150 x-3053 or benefits@palomar.edu.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Anthem Full Network HMO 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 Palomar Community College District Benefits Office at 760-744-1150 x-3053 or benefits@palomar.edu.

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Divulgación de protección de pacientes

Anthem Full Network HMO exige, en general, la designación de un proveedor de cuidados primarios. Usted tiene derecho a designar a cualquier proveedor de cuidados primarios que participe en nuestra red y esté disponible para aceptarlo(a) a usted o a sus familiares. Hasta que usted realice esta designación, Palomar Community College District Benefits Office designa uno para usted. Para obtener información sobre cómo seleccionar un proveedor de cuidados primarios, y para una lista de los proveedores de cuidado primarios participantes, comuníquese con el Palomar Community College District Benefits Office at 760-744-1150 x-3053 or benefits@palomar.edu.

Para los menores, usted podrá designar un pediatra como el proveedor de cuidados primarios.

Usted no necesita autorización previa de Anthem Full Network HMO o de cualquier otra persona (incluido un proveedor de cuidados primarios) a fin de obtener acceso a atención obstétrica o ginecológica de un profesional de salud en nuestra red que se especialice en obstetricia o ginecología. Sin embargo, el profesional de salud puede ser requerido conformarse con ciertos procedimientos, inclusive obtener autorización previa para ciertos servicios, siguiendo un plan de tratamiento previamente aprobado, o procedimientos de hacer referidos. Para obtener una lista de profesionales de salud participantes especializados en obstetricia o ginecología, comuníquese con el Palomar Community College District Benefits Office at 760-744-1150 x-3053 o benefits@palomar.edu.

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Special Enrollment Notice

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 toward 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).

In addition, 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.

To request special enrollment or obtain more information, contact Veronica Sadowski, Benefits Technician, 760-744-1150 x-3053 or email benefits@palomar.edu.

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Women's Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 760-744-1150 x-3053 for more information.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy
- was performed;
- Surgery and reconstruction of the other breast to produce a
- symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: varies by the type of medical plan (review the plan summary or evidence of coverage).

If you would like more information on WHCRA benefits, call your plan administrator 760-744-1150 x-3053 or email benefits@palomar.edu.