MSJC
Mt. San Jacinto College

2021-2022 Open Enrollment

Welcome to 2021 Open Enrollment! We realize the success of Mt. San Jacinto College depends on the commitment, dedication and well-being of our greatest asset – our employees. We are constantly striving to offer a wide variety of competitive, comprehensive benefits program with choices and the flexibility to customize your benefits package that best suit your individual and family needs.

Annual Benefits Online Open Enrollment is from May 1, 2021 to June 2, 2021

This year will be a "**CHANGES ONLY" OPEN ENROLLMENT"** for all benefit eligible employees. This means, all plan selections from the prior year will be carried over to 2021 plan year, unless the employee would like to make elections for any of the following reasons:

- Add or change benefit selections
- Add or delete dependents
- Enroll or re-enroll in the Flexible Spending Account (FSA) plan(s)
- Increase or decrease your Voluntary Life and AD&D Amounts
- Update your beneficiary(ies)

AIRBO Virtual Health Fair

Social distancing and working remotely has changed the way we live and work. We are now bringing the fair to your home using the Airbo platform. Airbo is an interactive, cloud-based platform which delivers information on your benefits. Click on the link to visit the Virtual Health Fair- https://app.airbo.com/ard/mt-san-jacinto-cc-2021.

When to Enroll

Open Enrollment starts on Monday, May 3, 2021 at 8am and will continue through Wednesday, June 2, 2021 at 4pm. Any changes made to benefits during this open enrollment period will go into effect July 01, 2021.

The benefit choices you make during Open Enrollment cannot be changed until the next years Open Enrollment window. Unless, you experience a qualifying life event such as a birth, adoption, death, marriage, divorce, or change in your or your spouse's job status, you can add/delete dependents only within 30 days of the qualifying event.

How to Enroll

If you are making changes to your benefits or updating beneficiaries, you can log into the online benefits portal, at **www.benefitbridge.com/msjc** . Instructions on accessing ***BenefitBridge*** are included in this package.

If you are enrolling a spouse, domestic partner, or child(ren) for the first time, you will need to provide supporting documentation to the Benefits Office showing proof of eligibility or upload the document on to ***BenefitBridge.*** For assistance, call the ***BenefitBridge*** Customer Service hotline at (800) 814-1862 (Mon – Fri 8am to 5pm). All benefits questions should be directed to the District Benefits Office, contact information provided on next page.

This guide provides highlights of what is new, updated, enhanced and available to you during this 2021 Open Enrollment. More specific information can be found on ***BenefitBridge*** under the Resource Center (Library).

Want to Learn about Benefits

Register and join one of the Virtual Benefits Presentation to be held on following dates:

Date	Time	Topic	Click on ZOOM Registration Link
Monday, May 3, 2021	10am – 11am	Benefits 101	Register Here
Thursday, May 6, 2021	3pm – 4pm	Benefits 101	Register Here
Monday, May 10, 2021	3pm – 4pm	CompleteCare	Register Here
Thursday, May 13, 2021	2pm – 3pm	HRA/Medicare 101	Register Here

Contact Information

Our goal is to make certain that you receive the correct coverage under the benefit plans. We are here to help, follow these steps if you require assistance:

- Do you need an ID card? If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.
- For claims assistance, please contact the insurance carrier. You will need your ID number or Social Security number along with date of service and provider name.
- If you need additional assistance or have questions, please contact the District Benefits Office at 951-880-1890 or Keenan & Associates at 800-654-8347 ext.1168 or 1140.

Benefit	Carrier	Contact	Website
Anthem Blue Cross HMO	Anthem Blue Cross	800.288.6921	www.anthem.com/ca
Anthem Blue Cross PPO & HSA	Anthem Blue Cross	800.627.7244	www.anthem.com/ca
Prescription Drug Plan (For All Anthem Plans)	Express Scripts	888.806.4969	www.express-scripts.com
Kaiser HMO	Kaiser Permanente	800.464.4000	www.kp.org
Anthem Dental PPO	Anthem Blue Cross	800.438-6388	www.anthem.com/provider/dental
Delta Dental PPO	Delta Dental	866.499.3001	www.deltadentalins.com
MetLife Dental HMO	MetLife Dental	800.880.1800	www.metlife.com/insurance/dental
Vision	Medical Eye Services (MES)	800-877.6372	www.mesvision.com
Vision	Vision Service Plan (VSP)	800.852.7600	www.vsp.com
Online Benefits Portal	BenefitBridge	800.814.1862	www.benefitbridge.com/msjc
Employee Assistance Program (For all Employees)	Anthem Blue Cross	800.999.7222	www.anthemEAP.com
Virtual Mental Health (Only for Employees Enrolled in a Medical Plan)	Talkspace	partners-support@talkspace.com	www.talkspace.com/reep
Wellness Condition Management Program	Omada Health	888.409.8687	omadahealth.com/reep
Hearing Aid (Discount Program)	TruHearing	844.524.3976	www.TruHearing.com/Choice
Basic and Voluntary Life and Accidental Death and Dismemberment Insurance	MetLife	Contact Keenan or District Office	www.metlife.com
Medical Bridge/Hospital Confinement plan	Colonial	844.624.1380	visityouville.com/REEP
Early Retiree HRA	MidAmerica	800.654.8347	www.mymidamerica.com
CompleteCare - Spousal Advantage Medical Expense Reimbursement Plan	Catilize Health	877.872.4232	www.catilize.com
Medical FSA and Dependent Day Care FSA	American Fidelity	800. 365.9180	https://enroll.americanfidelity.com/E56744CB
Legal Plan	MetLife Legal	800.438.6388	www.metlife.com/insurance/legal-plans
Long Term Care (LTC)	UNUM	866-679-3054	http://unuminfo.com/REEP/index.aspx
Identity Fraud and Resolution Service	Identity TheftPROTECTOR	866.262.5844	www.idtheftassist.com

Medical . Prescription . Dental . Vision . Life . Voluntary Plans

UPDATES & NEW OFFERINGS

The Medical, Dental, Vision, Voluntary and Value-Added benefits available to our employees are provided through REEP JPA

Anthem Blue Cross Plans

Anthem HMO Plans- HMO 20, HMO 30 and DHMO 40 Select

- There are no changes to the medical HMO benefits for 2021-2022 plan year.
- ***New*** – DHMO 40 Select will now be referred to as DHMO 500

Note: *DHMO 500 Select is a narrow network plan. It is important to know Anthem Blue Cross may "refresh" their narrow network providers on January 1st each year. While it doesn't happen often, changes can occur in the network providers yearly on January 1st. You will be notified in advance of January 1st if your provider is leaving the Anthem Select network. To determine if your HMO medical in the Anthem DHMO Select, visit: www.anthem.com/ca/findadoctor*

Anthem PPO 500, 750, 1250 Essentials and Minimum Value Plan (MVP)

- There are no changes to the medical PPO benefits for 2021-2022 plan year.

Health Savings Account Compatible PPO Plans

- There are no changes to the medical H.S.A. plans and benefits for 2021-2022 plan year.

Anthem LiveHealth Online (LHO)

Anthem LiveHealth Online (LHO) was provided to Anthem subscribers and their enrolled dependents with no member copay for HMO and PPO members beginning July 1, 2020 (IRS Regulations do not allow the copay to be waived for HSA members; however, the IRS waived these requirements for a period due to the COVID-19 outbreak). This program provides around the clock, 24/7 board-certified physicians benefits and referrals. More information is available on the Airbo Virtual Health Fair, in ***BenefitBridge*** or at the District Benefits Office.

BridgeHealth Program for Anthem PPO/MVP and HSA Members

BridgeHealth program is available to all Anthem PPO/MVP and HSA members. This program incentivizes the use of Centers of Excellence for elective surgeries such as cardiac, general, joint replacement, orthopedic, spinal, women's health, etc. If PPO/HSA/MVP members are referred for surgery, they can contact BridgeHealth to be guided to facilities and providers who are performing in the top 25% for that specific surgery.

If you opt to use the BridgeHealth program for your surgery, PPO members will have your deductible and coinsurance waived. HSA members will be subject to the deductible; however, your coinsurance will be waived, and you will receive a "care allowance" as follows:

- HSA 1500 Care Allowance: $1,500

- If traveling to a facility over 100 miles away, travel expenses are covered for the member and a companion to travel with you (includes airfare, lodging, incidentals)
- Members can call and receive a second opinion at no charge, and can decide not to move forward if you would rather pursue a different course of action
- Bundled contracts cover all costs from pre-op to post-op. Note this includes anesthesiology, so this removes the surprise bill that comes from non-contracted anesthesiologists.
- Members must call to begin the process, there is no outreach.
- More information is available on Airbo Virtual Health Fair, ***BenefitBridge*** or the District Benefits Office.

Express Scripts Prescription Drug Plans (for Anthem Plans)

Express Scripts Prescription Drug Plans

- There are no changes to the prescription benefits, for 2021-2022 plan year.

Keenan Pharmacy Care Management (KPCM) Programs will continue-

- Pharmacy Vaccination Program continues for REEP Anthem PPO/HSA/MVP members. PPO / HSA / MVP members will have access to vaccines at the pharmacy. REEP HMO members can still get their vaccinations through their provider/medical group.
- Migraine Care Value Program continues for all REEP Anthem members. This program provides Exclusive Home Delivery for members taking CGRP inhibitors and creates medication reliability, improves clinical outcomes and maximizes savings.
- KPCM is a prescription intervention program that targets high cost prescriptions where lower cost alternatives are available (for REEP Anthem members). When a high cost medication is prescribed it automatically triggers a call to the prescribing doctor to determine whether the doctor agrees that the member could consider taking a lower cost alternative. If so, the member is contacted to see if they would like to consider filling an alternative prescription approved by their doctor. Ultimately it is up to the doctor and the member to make the decision to change.

Kaiser Plans

Kaiser HMO 20, DHMO 500, MVP and H.S.A

- There are no changes to the medical benefits for 2021-2022 plan year.

Employee Assistance Program (EAP)

Employee Assistance Program (EAP)

For All Employees (Anthem Blue Cross, Kaiser and Non-benefit Eligible Employees)

- There are no changes to the EAP benefits, for 2021-2022 plan year.
  The EAP is provided through Anthem Blue Cross to **all employees** of the district and all immediate family members living in your household, even if you are not eligible for benefits. EAP services are confidential. Your privacy is important, and it is protected by state and federal laws. EAP provides strictly confidential, 24-hour counseling services (in-person and telephone sessions) to help you and your dependents manage a variety of issues, including family concerns, stress, financial worries, depression, substance abuse, work-related conflict, and legal matters. The EAP Program also provides five (5) free, counseling sessions per year for each issue or concern with a licensed clinician.
  If you are an Anthem Blue Cross member, the phone number to access this benefit will be listed on your Anthem ID card. All Kaiser members, or non-benefit eligible employees, should refer to the flyer included on the district website. More information is available on the Airbo Virtual Health Fair, in ***BenefitBridge*** or at the District Benefits Office

- REEP members have access to Mystrength.com. Mystrength.com provides a free online and mobile program that supports emotional health and wellbeing. Members can access the information online or through the convenient Mystrength app on the Android and Apple markets.
  - Kaiser My Strength, please search www.Kp.org/selfcareapps/scal to get started.
  - Anthem My Strength, please search www.Anthem.com/ca/mystrength to get started.

Note: EAP benefits are **separate** from the mental health and substance abuse benefits.

Talkspace

Talkspace – Online Therapy

New - Talkspace is a new way to seek mental health support through text and web messaging. This benefit is ***in addition*** to the mental health benefits provided under your Anthem or Kaiser plan, and ***in addition*** to the Anthem Employee Assistance Plan (EAP). With Talkspace, you can choose your therapist from a list of recommended, licensed providers and receive support day and night from the convenience of your device (iOS, Android, and Web). This benefit is available to you and your family members age 13 and over. Talkspace provides unlimited text and voice messaging at no copayment with a personal therapist immediately after registration. Therapists engage daily, 5 days per week, which often includes weekends. To use the Talkspace benefit visit www.talkspace.com/reep

More information is available on the Airbo Virtual Health Fair, in ***BenefitBridge*** or at the District Benefits Office.

OMADA Wellness

OMADA Health for Anthem Blue Cross and Kaiser Permanente Members

OMADA Health program is focused on diabetes/hypertension and weight management and will be offered to REEP employees enrolled in either Anthem or Kaiser Permanente who qualify to participate. The goal of this program is to help REEP members:

- Lose weight (and keep it off) with small, sustainable lifestyle changes
- Build strategies for healthy eating, activity, sleep and stress management
- Reduce the risk of developing type 2 diabetes, heart disease and stroke

The OMADA Health program will provide qualifying REEP members with the following:

- A dedicated, professional health coach provides participants with proactive, real-time support and motivation throughout the entire program
- Rigorous scientific data analysis – in real-time – is used to determine exactly how to deliver the right personalized interventions, at the right time, to each individual participant
- Participants are matched into online peer groups for encouragement and healthy competition
- Participants learn how to eat healthier, increase activity levels, and overcome challenges through fun games and interactive lessons
- Connected scale, web and mobile apps track weight, activity and food.
- More information is available on the Airbo Virtual Health Fair, in ***BenefitBridge*** or at the District

Dental Plans

Anthem Dental

- There are no changes to the Anthem Dental plan benefits for 2021-2022 plan year.

Delta Dental

- There are no changes to the Delta Dental plan designs benefits for 2021-2022 plan year.

MetLife Dental DHMO

- There are no changes to the MetLife Dental plan designs benefits for 2021-2022 plan year.

Vision Plans

Medical Eye Services (MES) Vision

- ***Enhancement Frame Benefit:***
  The Medical Eye Services plan has been enhanced to provide a frame and contact lens benefit allowance of $125 per calendar year. This is an increase from $90 frame and $100 contact lens.

Vision Service Plan (VSP) Vision

- There are no changes to the Vision Service Plan (VSP) plan benefits for 2021-2022 plan year.

TruHearing Program

TruHearing Discount Program

REEP continues to offer the TruHearing Discount Program, all members have access to hearing aids at a far reduced price. REEP members can shop state of the art hearing aid technology at a savings between 30% to 60% off. Information on this benefit is available on the district website.

MetLife Group Life and Accidental Death and Dismemberment

MetLife Group Life and AD&D

- The district provides life insurance to all active benefit eligible employees
- All employees currently enrolled in the Group Life and AD&D plans are encouraged to review their beneficiary(ies) designation in ***BenefitBridge*** and update if needed.

Additional Voluntary Benefits

The district offers all active benefit eligible employees and their dependents, the opportunity to purchase voluntary benefits, as outlined below. If you are currently enrolled in any of these voluntary plans, most of these benefits do not require re-enrollment. The only exception is Flexible Spending, which requires your re-enrollment, even if you are electing the same amount as last year. If you wish to enroll in a new voluntary plan, you can do so online through ***BenefitBridge***.

American Fidelity – Section 125 Re-Enrollment

American Fidelity provides you the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through Flexible Spending Accounts. You must enroll/re-enroll in the plan to participate for the plan year July 1 – June 30, 2022.

Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay federal income tax, Social Security taxes, or state and local income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period. Medical FSA and Dependent Day Care FSA will require you to complete your enrollment for the new plan year – even if you are electing the same dollar amount, you must re-enroll in the FSA each year. To do this, you will need to schedule a virtual appointment with an American Fidelity (AF) representative. There are two (2) ways you can schedule your appointment. While making your plan selections on ***BenefitBridge***, you will be given the option to click on the following link - https://enroll.americanfidelity.com/E56744CB to schedule your appointment online, or you can contact AF at (800) 365-9180 ext. 0.

Colonial Medical Bridge

Colonial Medical Bridge offering continues this year. There are four (4) Medical Bridge plans to choose from which could help pay for out-of-pocket medical expenses, such as deductibles, co-payments and other expenses, and will also reimburse you for some preventive screenings.

You can view the details of the available plans and/or elect to enroll in a Medical Bridge plan online through ***BenefitBridge***. More information is available on the Airbo Virtual Health Fair, in ***BenefitBridge*** or at the District Benefits Office.

CompleteCare - Spousal Advantage Medical Expense Reimbursement Plan

REEP CompleteCare Medical Expense Reimbursement Plan. If you or your dependents have access to group health coverage through your spouse. This plan may be a great cost savings for you.

The CompleteCare plan is a medical expense reimbursement plan designed for employees who have access to group health coverage through a spouse or domestic partner. Under the CompleteCare plan, you could potentially have no out-of-pocket costs for you or your dependents when covered by your spouse's employer health plan. Copays, deductibles, coinsurance, etc. will be reimbursed up to 100% when you and/or your dependents enroll in the CompleteCare plan through REEP and enroll in your spouse's employer health plan.

This plan could not only mitigate, or eliminate, your district payroll deduction, if you have one, but it could cover you and your dependents for up to 100% of out-of-pocket medical costs. To be eligible:

- You must currently be enrolled in one of the district's health plans
- You or your dependents must have access to group health coverage through your spouse's employer
- Your spouse or domestic partner's employer cannot be another REEP medical district
- To learn more about the CompleteCare program, attend one of the webinars listed on the cover page or click on the link to learn how it works - https://keenan.wistia.com/medias/acl7bhsb3z

HRA Plan Offering

Are you retiring soon? Do you want more choice when looking for the right health insurance coverage? The Health Reimbursement Arrangement (HRA) may be for you.

For benefit eligible employees, who are retiring soon, (i.e. July 1, 2021), you have the opportunity to voluntarily shop for health care coverage outside of the medical plans offered by the District. This program provides you the opportunity to comparison shop for more affordable health care coverage that fits your health care needs and your budget. If you find a more affordable health care plan that you would like to enroll in, you can access your negotiated District contribution to purchase that coverage through a Health Reimbursement Account (HRA). The HRA offers you several tax advantages and if you are interested in this program, attend one of the webinars listed on the cover page or contact the District Benefits office, or a Keenan representative.

Identity TheftPROTECTOR Plan

REEP is offering the most comprehensive and affordable identity fraud and resolution service available today. For $10.00 per month ($12.00 tenthly) you can protect your entire family against identity theft and fraud. More information is available on the Airbo Virtual Health Fair, in ***BenefitBridge*** or at the District Benefits Office.

UNUM Long Term Care (LTC)

Long Term Care plans are available through UNUM at group rates. Additional information, rates and enrollment can be found by logging into the following website: http://unuminfo.com/REEP/index.aspx

MetLife Legal Plan

Unlimited services covered under this plan include: wills, living wills and trust preparation; purchase, sale and refinancing of primary residence, debt collection defense, identity theft assistance, landlord/tenant problems, civil litigation defense, document preparation, adoptions and more. Formally known as MetLaw/Hyatt Legal._More information is available on the Airbo Virtual Health Fair, in ***BenefitBridge*** or at the District Benefits Office.

MetLife Voluntary Life Insurance

Life Insurance is so Important! During Open Enrollment, you may elect additional life insurance or increase your existing coverage for yourself and your eligible dependents. If you're enrolling in life coverage, you may apply for spousal life coverage up to 100% of your amount of coverage, not to exceed $500,000 or 5 times the employee's annual salary. The coverage must be in increments of $10,000. If you're enrolling in life coverage, you may also apply for supplemental life coverage for your child(ren) to a maximum of $10,000.

Election of additional life insurance will require the completion of a MetLife Statement of Health (SOH) form. You will be prompted, as you are completing your online enrollment on ***BenefitBridge,*** to download the form. The completed SOH form should be returned to the Benefits Office to forward to MetLife for approval.

If you are already enrolled and wish to make no changes to your current plan, it is advisable that you log into ***BenefitBridge*** and ensure your beneficiary information is up to date.

Please Note: When applying, if you do not complete the required Statement of Health Form (SOH), you and/or your dependents will not be approved and will not be enrolled in Voluntary Life insurance coverage.

MetLife Voluntary Accidental Death & Dismemberment (AD&D) Insurance

If you missed the opportunity to purchase Voluntary AD&D, you may elect this insurance or increase your current benefit, by purchasing additional coverage not to exceed 10 times your annual income at an affordable cost. The basic purpose of AD&D insurance is to provide for many of the unexpected expenses that a family faces following a tragedy.

This plan is available to enroll in online through ***BenefitBridge***. Should you decide you do not wish to purchase additional Voluntary AD&D coverage, you are encouraged to still name a beneficiary as you will be provided with a "no cost" $2,000 benefit as long as you enroll online for the basic $2,000 no cost benefit.

Important Information ***Regarding the MetLife Voluntary Life and Voluntary AD&D Insurance***

- **Dual Coverage Not Allowed** - If you are married to a school district employee who is covered under this plan as an employee, each employee has the choice to elect to enroll as a subscriber or enroll as a spouse under your plan, however you cannot have dual coverage under each other. If you have children, the children can only be covered under one of the employee's plan.

- Dependent children are covered up to age 26. If you have purchased coverage for your children, it is important to remember that once your youngest child reaches age 26, it is your responsibility to notify the District Benefits Office to remove the dependent coverage. Once the district is notified, your payroll deduction for this plan will be adjusted.

- This benefit enables you to continue the coverage at no cost while you are off work due to a total disability. Contact the District Benefits Office for more information.

Important Reminders

1. Governmental regulations require all employees carry medical insurance. Therefore, any employee who declines Mt. San Jacinto CC group medical insurance plan each year must denote on ***BenefitBridge*** that you are waiving medical insurance, electing not to enroll in the plan(s) offered by the district.

2. Qualified events allow you to make changes to your benefits during the plan year rather than waiting for the next annual open enrollment period. If you experience a special enrollment circumstance or change in family status such as birth of a child, marriage or divorce, please contact the Benefits Office to discuss. It is important to note, you must make this change within 30 days of the qualifying event.

3. Once you make your plan elections, you cannot change to a different plan until the next open enrollment period without a qualifying event. A loss or change of provider is not considered a qualifying event.

4. If your physician is no longer an eligible provider for the plan you have chosen, you must choose a new participating provider, or the carrier will select one on your behalf.

5. Eligible dependents include your spouse, registered domestic partner, and your children up to their 26th birthday (or your dependent child(ren) of any age who is totally disabled prior to age 26). This includes natural children, step children, adopted children and children for whom you are a court appointed guardian. This also includes any child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSD).

6. All employees enrolled in one of the Voluntary Life or Voluntary AD&D plans should log on to ***BenefitBridge*** and update your beneficiary information to ensure your designated beneficiary(ies) is/are current.

7. You must remain enrolled in your selected plan until July 1, 2021. Changes to other medical plans or insurance carriers are not allowed outside open enrollment.

What Should I Do Next?

1. Review your insurance benefits and decide what is best for you and your family.

2. Log on to ***BenefitBridge*** at **www.benefitbridge.com/msjc** to elect the plans of your choice, update your beneficiary(ies) on the life plan(s), and verify your elections are accurate. A flyer on how to navigate ***BenefitBridge*** is included in this enrollment guide.

BenefitBridge
A Keenan Solution

2021 Online Benefits Enrollment

Mt. San Jacinto Community College District Online Benefits Enrollment is easy with BenefitBridge!

Need Help?

For all questions related to your benefits:

For BenefitBridge technical assistance only, please contact BenefitBridge Customer Care at 800. 814.1862; Mon - Fri, 8:00 AM - 5:00 PM PST or email benefitbridge@keenan.com.

Here's what you can do on BenefitBridge:

- View Current Plan Year Benefits
- Compare Plan Options
- Enroll in Benefit
- Resource Center: Health Insurance Basics, Medicare, Glossary, Media Resources
- Learn more about the Group Medical Bridge plan available with Colonial Life through Building Blocks! For more information click here! For questions, contact Building Blocks by calling 844-624-1380 or emailing westservice@bbforb.com.
- Add or Remove Dependents/Beneficiaries
- Message Center
- Update My Account Info
- Available 24/7 via the Internet

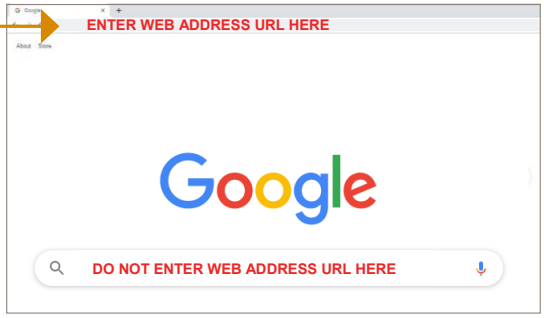
Registration and Login

Already have login credentials?

1. Login to **BenefitBridge** at www.benefitbridge.com/msjc
2. Forgot your Username or Password? Click on **"Forgot Username/Password?"**

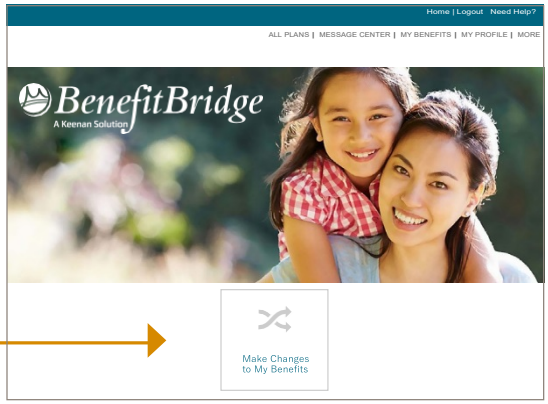
Need to create login credentials?

1. In the **address bar**, type www.benefitbridge.com/msjc **(Not in the Bing, Google, Yahoo search engine field)**
2. Click the **Enter** key, then follow the instructions below to register:
   - **STEP 1:** Select **"Register"** to **Create an Account**
   - **STEP 2:** Create a **Username** and **Password**
   - **STEP 3:** Select **"Continue"** to access **BenefitBridge**



Enrolling in Benefits

Access your enrollment via the **"Make Changes to My Benefits"** button



IMPORTANT NOTICES

2021

MSJC
MT. SAN JACINTO COLLEGE

Important Notices

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn generally may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

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. For more information, you should review the Summary Plan Description or call your Plan Administrator at (951) 880-1890.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact Anthem or Kaiser Customer Service at the phone number on the back of your member ID card.

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

You do not need prior authorization from the plan or 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, please contact Anthem or Kaiser Customer Service at the phone number on the back of your member ID card.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Anthem and Kaiser. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims, and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

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 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 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 does not accept late enrollees.

Important Notices

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 are an employee, you will become a Qualified Beneficiary if you lose 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 are the spouse of an employee, you will 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 their 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 employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The employer must notify the Plan Administrator of the following Qualifying Events:

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

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number and Social Security Number; the full name, address, phone number and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

Important Notices

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

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 on behalf of their dependent 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.

DISABILITY EXTENSION OF THE 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. This 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. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of 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 receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (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 the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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.

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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.

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

Important Notices

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.

IF YOU HAVE QUESTIONS

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 subject to ERISA, 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. (Address 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.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

Important Notices

See the Summary Plan Description or contact the Plan Administrator for more information.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

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 there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or Qualified Medical Child Support Order, you may be able to enroll yourself and / or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Lanell Covington-James
Human Resources/Benefits Analyst
(951) 880-1890

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Mt. San Jacinto Community College 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:

- **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.**

Important Notices

- **Mt. San Jacinto CC/Express Scripts/Kaiser has determined that the prescription drug coverage offered by Mt. San Jacinto Community College 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 Mt. San Jacinto Community College coverage will not be affected. If you keep this coverage and elect Medicare, the Mt. San Jacinto Community College coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Mt. San Jacinto Community College coverage, be aware that you and your dependents will 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 Mt. San Jacinto Community College 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 (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information. **Note:** You will 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 Mt. San Jacinto Community College 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 will 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 your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

REMEMBER

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

Date:	May 2021
Name of Entity / Sender:	Mt. San Jacinto Community College
Contact:	Lanell Covington-James
Address:	1499 N. State Street San Jacinto, CA 92583
Phone:	(951) 880-1890

Important Notices

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Mt. San Jacinto Community College's Anthem and Kaiser Health Plans maintain a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Lanell Covington-James at (951) 880-1890.

Important Notice Regarding Wellness Information

The REEP Wellness Program is a voluntary program available to all employees who participate in Anthem or Kaiser. and is subject to federal law including the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.

If you choose to participate, you may be asked to complete a voluntary health risk assessment that asks questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You may also be asked to complete a voluntary biometric screening which includes cholesterol, glucose, blood pressure, BMI and Body Fat.

The information gathered from your health risk assessment and/or biometric screening will be used to provide you with information to help you understand your current health, potential risks, and may also be used to offer you services through the wellness program. You are also encouraged to share your results or concerns with your own doctor.

The law requires us to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Mt. San Jacinto Community College may use aggregate, non-employee specific information to design a program to address health risks in the workplace, your personal identifiable information will never be disclosed publicly or to your employer. Medical information that personally identifies you in connection with the wellness program will not be disclosed to your supervisors or managers and will never be used to make decisions regarding your employment. Anyone (e.g., a registered nurse, a doctor, health coach, etc.) who receives information about you for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

All medical information obtained through the wellness program will be confidential.

If you have any questions or concerns, please contact Lanell Covington-James at (951) 880-1890.

Important Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Mt. San Jacinto Community College in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California will begin November 1, 2020, and is anticipated to end on the following January 31. Open Enrollment for most other states will begin on November 1 and close on December 15 of each year.

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 you coverage, offers medical coverage that is not “Affordable,” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.83% (for 2021) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s medical plan.

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 medical 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.

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com.

3. Employer name Mt. San Jacinto Community College	**4. Employer Identification Number (EIN)** 96-6000929	
5. Employer address 1499 N. State Street	**6. Employer phone number** (951) 880-1890	
7. City San Jacinto	**8. State** CA	**9. ZIP code** 92583
10. Who can we contact about employee health coverage at this job? Lanell Covington-James, Human Resources/Benefits Analyst		
11. Phone number (if different from above)	**12. Email address** ljames@msjc.edu	

Important Notices

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 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 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, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916.445.8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado
Colorado's Medicaid Program & Child Health Plan Plus (CHIP+)
Healthy First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 800.221.3943
TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 800.359.1991
TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877.357.3268

GEORGIA – Medicaid
Website: http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678.564.1162, ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877.438.4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800.338.8366
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888.346.9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800.792.4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855.459.6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877.524.4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888.342.6207 (Medicaid hotline) or
855.618.5488 (LaHIPP)

Important Notices

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 800.862.4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800.657.3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800.694.3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov/
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603.271.5218
Toll-Free for the HIPP program: 800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
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: 800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800.541.2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888.365.3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800.699.9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 800.692.7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347, or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888.549.0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888.828.0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877.543.7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800.250.8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 800.432.5924
CHIP Phone: 855.242.8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800.562.3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800.362.3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800.251.1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565