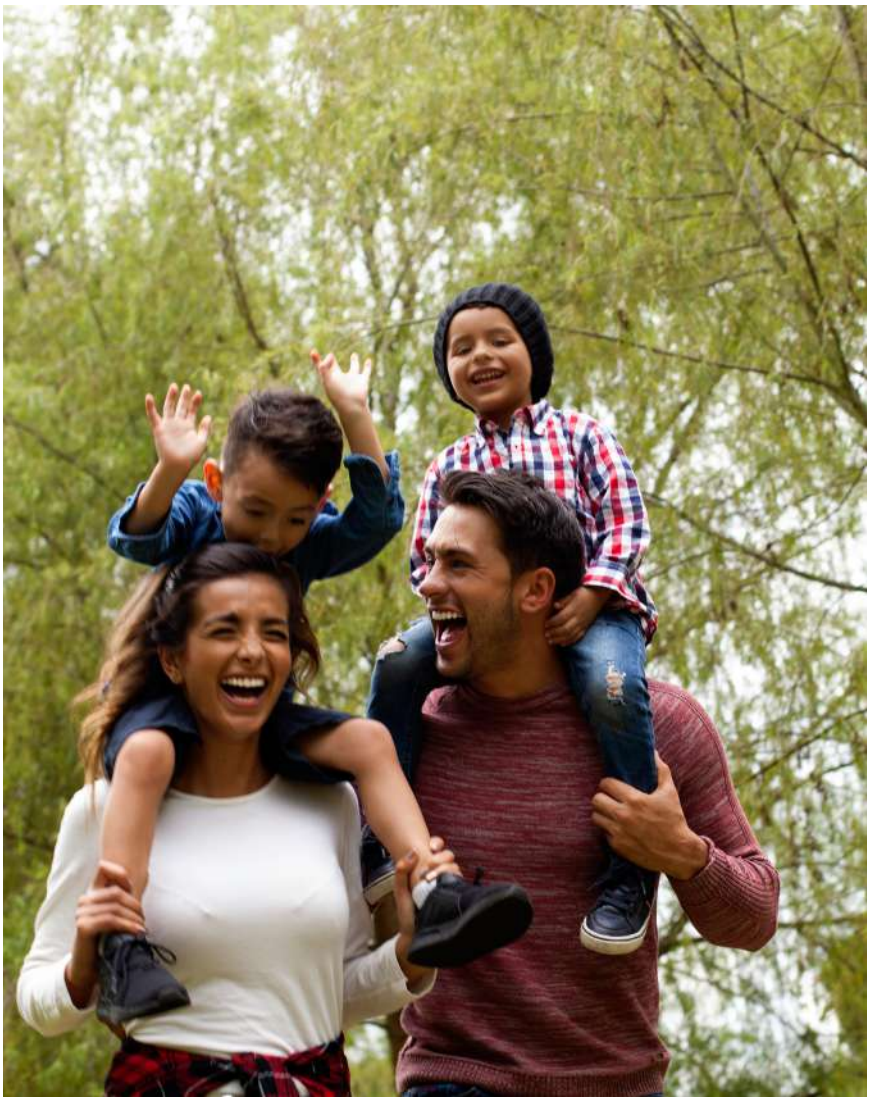
OCASA



2023 - 2024 BENEFITS GUIDE

EFFECTIVE JULY 1, 2023 – JUNE 30, 2024

INTRODUCTION

Welcome!

Orange County Academy of Sciences and Art recognizes the importance of having a comprehensive benefits program. Our program is designed to provide you and your family a variety of plans with tools that promote health and wellness. We are committed to making every effort to provide benefits that support the lifestyles and needs of our employees.

Benefit Options for 2023-2024

Review this guide to learn about the benefits available to you. Then choose the options that are best for you and your family.

Below is a summary of the generous package available to you:

- **Medical coverage through Anthem**
- **Medical coverage through Kaiser**
- **Dental coverage through Anthem**
- **Vision coverage through Anthem**
- **Flexible Spending Account services through Igoe**
- **Basic Life and AD&D coverage through Anthem**
- **Supplemental Life and AD&D coverage through Anthem - New Benefit**
- **Voluntary Short-Term Disability through UNUM**
- **Voluntary Accident, Critical Illness, and Hospital Indemnity coverage through UNUM**

CA Individual Mandate

- **Effective January 1, 2020 California has an individual healthcare mandate in effect.**
- **This mandate will tax CA residents (including dependents) who do not have health insurance.**
- **This state mandate serves to ensure stability in California's individual healthcare market by increasing participation of those who are "young and healthy".**
- **Tax penalties are determined by the California Franchise Tax Board (FTB) and may be a flat dollar amount per person, or a percentage of the gross annual income. Penalty amounts may change annually.**
- **For more information and guidance on your personal situation and potential exemption options, please consult with a tax professional.**

When To Enroll

You can only sign up for benefits or change your benefits at the following times:

- **When you are newly hired as a Orange County Academy of Sciences and Art employee. Your benefit coverage begins on the first of the month following 0 days after your hire date.**
- **During the annual benefits open enrollment period. See page 3.**
- **Within 30 days of a qualifying life event: See page 3 and contact Orange County Academy of Sciences and Art Human Resources Department for more information.**

The choices you make at this time will remain in place until the end of your plan year, unless you experience a qualifying life event. If you do not sign up for benefits during your initial eligibility period, you will not be able to elect coverage until the next annual open enrollment period.

ELIGIBILITY

Open Enrollment

Open enrollment occurs one time each year. During this time, you may add or remove dependents from your coverage, change your coverage level, or change your benefit elections without experiencing a qualifying event. The benefits and coverage you select during this open enrollment period will remain in effect until June 30, 2024, unless you experience a qualifying life event and submit plan changes.

Eligibility

Employees:
Full-time employees working 30+ hours per week are eligible to participate in the Orange County Academy of Sciences and Art benefit plan.

Dependents:
As an eligible employee, you may cover your legal spouse or registered domestic partner, dependent child(ren) up to the age of 26 (regardless of their student status) and unmarried dependent child(ren) over the carrier age limits who are physically or mentally incapable of self-support.

Qualifying Events for Changing Benefits

If you waive coverage at this time, you cannot enroll in Orange County Academy of Sciences and Art. Health Plan until the next open enrollment period, unless you have a qualifying event. You have 30 days from the time of the qualifying event to notify Human Resources to change your benefits. Examples of qualifying events include:

- **Change in marital status**
- **Birth or adoption of a child**
- **Death of a covered dependent**
- **Loss of eligibility status by a covered dependent**
- **Change in employment status that affects eligibility for coverage**
- **Losing or gaining healthcare coverage eligibility under Medicare or Medicaid**

INSURANCE BASICS

Medical HMO

An HMO is a plan that offers coverage within a specific network of doctors and hospitals. Coverage under an HMO is only available through providers and facilities that are in-network. If you visit a doctor that is not in the HMO network, you are responsible for 100% of the cost of services unless you're seeking emergency medical treatment.

Who should consider opting for a HMO?

Someone who is looking to pay reduced premiums, lower copays, and no coinsurance for in-network and covered services. HMOs are also great for patients who want a doctor dedicated to coordinating their care. Under an HMO plan, your primary care doctor (also called a primary care provider) will provide referrals when a specialist visit is necessary. An HMO could be a good option if your providers are contracted in the HMO network. An HMO plan may limit your ability to see doctors that you've seen in the past if they're not in-network.

Medical PPO

PPO plans typically have premiums and deductibles that are higher compared to HMO plans. They also offer greater flexibility, such as expanded networks and no referral requirements.

Who should consider opting for a PPO?

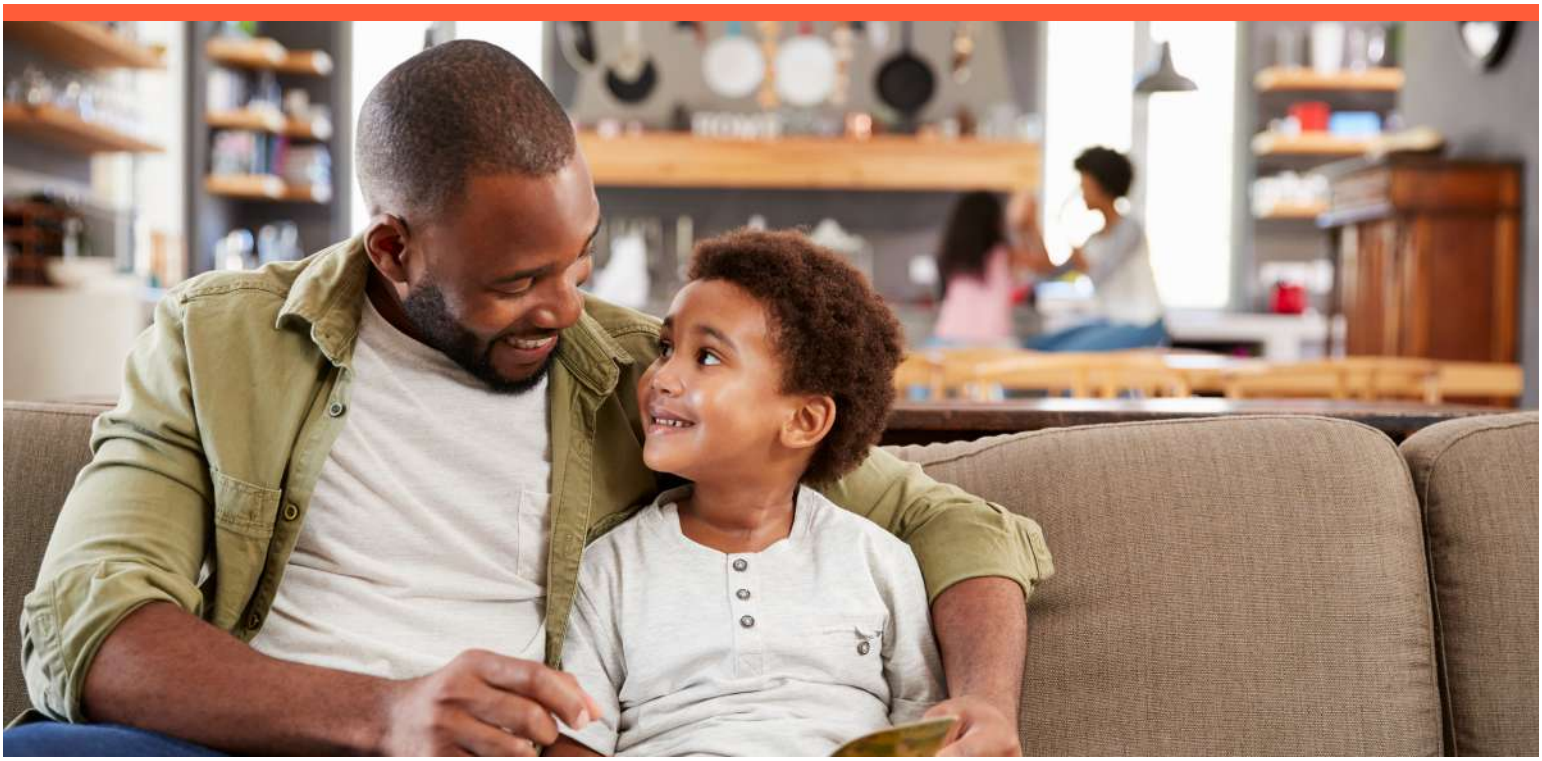
If you are looking for greater flexibility to book appointments with providers who are in the PPO network (as well as those out-of-network) without a referral. It's important to note that you may pay a higher rate if you choose to go out-of-network. If you travel often, or have covered dependents who live out of state a PPO plan might be a better fit.

Dental HMO (DHMO)

If you elect coverage in this plan, you must select a primary care dentist from the DHMO contracted provider list. All care must be provided by the primary dentist. A referral is required in order to visit a specialist. You may change dentists once each month. Changes made prior to the 15th of the month will take effect on the first of the following month.

Dental PPO (DPPO)

Similar to a medical PPO plan, a dental PPO allows you to choose an in-network or out-of-network provider. Remember, going out-of-network will be more costly than visiting an in-network dentist. If you need services or treatments that will cost $300 or more, it is strongly recommended to ask for a predetermination of benefits from your dentist to understand the cost of services. Please be advised that ID cards are not necessary, and DPPO members may not receive ID cards.



HOW TO FIND A PROVIDER

How To Find a Anthem Medical Provider

- Visit https://www.anthem.com/
- Select “Find a Doctor”
  - To search as a member: log in or use the identification number on your member ID card
  - To search as a guest: click on “search by selecting a plan/network”
- If searching as guest, complete the following fields:
  - Use the drop down to select type of care - Medical
  - Select a state - California
  - Select "Medical (Employer-Sponsored)"
  - Select a plan/network
    - For the HMO plan select: "Select HMO"
    - For the PPO plan select: "Blue Cross PPO (Prudent Buyer) - Large Group"
- Enter your specific search criteria (provider name, address, zip code etc) and click “Search”

View your search results. From this page you can email or print your results or return to search to edit your criteria

How To Find a Kaiser Medical Provider

- Visit www.kp.org
- Click **Choose your Region** and update your region on the top right corner of the page.
- Next, click on **Doctors & Locations** below the Kaiser Permanente logo**.**
- You can search by language, gender, specialty or location

Important Information about electing a PCP in Network (HMO) plans

▪ All HMO enrollees must select a PCP and designate their PCP #. If you enter an invalid PCP # or leave this blank, you will be auto assigned to a provider based on your home zip code. If you receive an ID with an incorrect PCP listed, please contact your carrier member services to correct.
▪ If you decide to change your PCP at any time, you can do this by phone or online.

Information about the PPO plan

▪ You have the option of choosing a primary care provider (PCP) to guide your care (it is recommended but not required). You can see a specialist without a referral.
▪ Using in-network doctors and health care facilities may keep your costs lower.
▪ You can choose out-of-network doctors or facilities, but your costs may be higher.
▪ You'll pay an annual amount called a deductible before the plan begins to pay for covered costs. Once you meet your deductible, you pay a copay or coinsurance amount and the plan pays the rest of covered costs.
▪ Once you meet an annual limit on your payments called an out-of-pocket maximum, your plan pays 100% of covered costs.

Finding a Dentist:

- Visit https://www.anthem.com/ca/find-care/
  - To search as a member: log in or use the identification number on your member ID card
  - To search as a guest: click on “Guests”
- If searching as guest, complete the following fields:
  - Use the drop down to select type of care - Dental
  - Select a state
  - Select "Dental"
  - Select the plan/network
- Click "Continue"
- Enter your specific search criteria (provider name, address, zip code etc) and click “Search”
- View your search results. From this page you can email or print your results or return to search to edit your criteria

Finding an Eye doctor:

- Visit https://www.anthem.com/
- Select “Find a Doctor”
  - To search as a member: log in or use the identification number on your member ID card
  - To search as a guest: click on “search by selecting a plan/network”
- If searching as guest, complete the following fields:
  - Use the drop down to select type of care - Vision
  - Select a state - California
  - Select "Vision"
  - Select your plan/network - Blue View Vision
- Enter your specific search criteria (provider name, address, zip code etc) and click “Search”

View your search results. From this page you can email or print your results or return to search to edit your criteria

MEDICAL COVERAGE: HMO OPTIONS

The following chart summarizes the benefits for the medical plans offered to all eligible employees of Orange County Academy of Sciences and Art. As an eligible employee, you may choose from one of the following plans.

LEARN MORE: Please note that the chart below is intended for comparison purposes only. For a comprehensive listing of what is covered and not covered under each plan, please refer to the Evidence of Coverage booklet.

	Anthem	Kaiser
	Gold Select HMO 35	Gold 80 HMO 1000/40 Alt
Annual Deductible Calendar year	$0 Individual $0 Family	$1,000 Individual $2,000 Family
Annual Out-of-Pocket Max Calendar year	$6,750 Individual $13,500 Family	$7,800 Individual $15,600 Family
Physicians Services		
Primary Care	$35 Copay	$40 Copay
Specialist Visits	$70 Copay	$60 Copay
Preventive Care	No charge	No charge
Hospital Services		
Inpatient Hospitalization	$750/day up to 4 days	$600/day up to 5 days*
Outpatient Surgery	$550 Copay	$350 Copay
Tests		
Advanced Imaging	$250 Copay	$350 Copay*
Diagnostic X-ray/Lab	$15 Copay	X-ray: $60 Copay / Lab: $30 Copay
Urgent / Emergency Care Visits		
Urgent Care	$35 Copay	$40 Copay
Emergency Room (Waived if admitted)	$325 Copay	$350 Copay
Prescriptions (Retail 30-day supply)		
Brand Name Rx Deductible	None	$250 Individual / $500 Family
Tier 1: Generic	$10 Copay	$20 Copay
Tier 2: Preferred Brand Name	$50 Copay	$50 Copay**
Tier 3: Non-Preferred Brand Name	$90 Copay	$50 Copay**
Tier 4: Specialty/Specialty Drugs	30% up to $250 per prescription	20% up to $250 per prescription**
Prescriptions available through mail order. See your summary of benefits for full details.		

*** After Deductible**
**** After Rx Deductible**

MEDICAL COVERAGE: PPO OPTION

The following chart summarizes the benefits for the medical plan offered to all eligible employees of Orange County Academy of Sciences and Art. As an eligible employee, you may choose to enroll in the following plan.

LEARN MORE: Please note that the chart below is intended for comparison purposes only. For a comprehensive listing of what is covered and not covered under each plan, please refer to the Evidence of Coverage booklet.

	Anthem	
	Gold PPO 35/500/25%	
	In-Network	Out-of-Network
Annual Deductible Calendar Year	$500 Individual $1,500 Family	$2,000 Individual $4,000 Family
Annual Out-of-Pocket Max. Calendar Year	$8,200 Individual $16,400 Family	$16,400 Individual $32,800 Family
Physicians Services		
Primary Care	$35 Copay	50%*
Specialist Visits	$65 Copay	50%*
Preventive Care	No charge	50%*
Hospital Services		
Inpatient Hospitalization	25%*	50%*
Outpatient Surgery	$200 Copay + 25%*	50% up to $650/day*
Tests		
Advanced Imaging	$100 Copay + 25%*	50% up to $380/admission*
Diagnostic X-ray/Lab	$15 Copay	50%*
Urgent / Emergency Care Visits		
Urgent Care	$35 Copay	50%*
Emergency Room (Waived if admitted)	$250 Copay + 25%*	Same as In-Network
Prescriptions (Retail 30-day supply)		
Brand Name Rx Deductible	$250 Individual / $500 Family	None
Tier 1: Generic	A: $10 Copay / B: $20 Copay	Not Covered
Tier 2: Preferred Brand Name	A: $50 Copay** / B: $60 Copay**	Not Covered
Tier 3: Non-Preferred Brand Name	A: $90 Copay** / B: $100 Copay**	Not Covered
Tier 4: Specialty/Specialty Drugs	A: 30% up to $250 per prescription** B: 40% up to $250 per prescription**	Not Covered
Prescriptions available through mail order. See your summary of benefits for full details.		

A: Level 1 Pharmacy
B: In-Network Provider

*** After Deductible**
**** After Rx Deductible**

FREQUENTLY ASKED QUESTIONS

What is a Deductible?
A deductible is the amount of money you or your dependents must pay toward a health claim before your organization's health plan makes any payments for health care services rendered.

What is Coinsurance?
Coinsurance is a provision in your health plan that describes the percentage of a medical bill that you must pay and that which the health plan must pay.

What is the Out-of-Pocket Maximum?
The maximum amount (includes deductible, coinsurance, copays, and prescription drug cost) that an insured will have to pay for covered expenses under a plan. Once the out-of-pocket maximum is reached, the plan will cover eligible expenses at 100%.

What is a Copay?
A fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

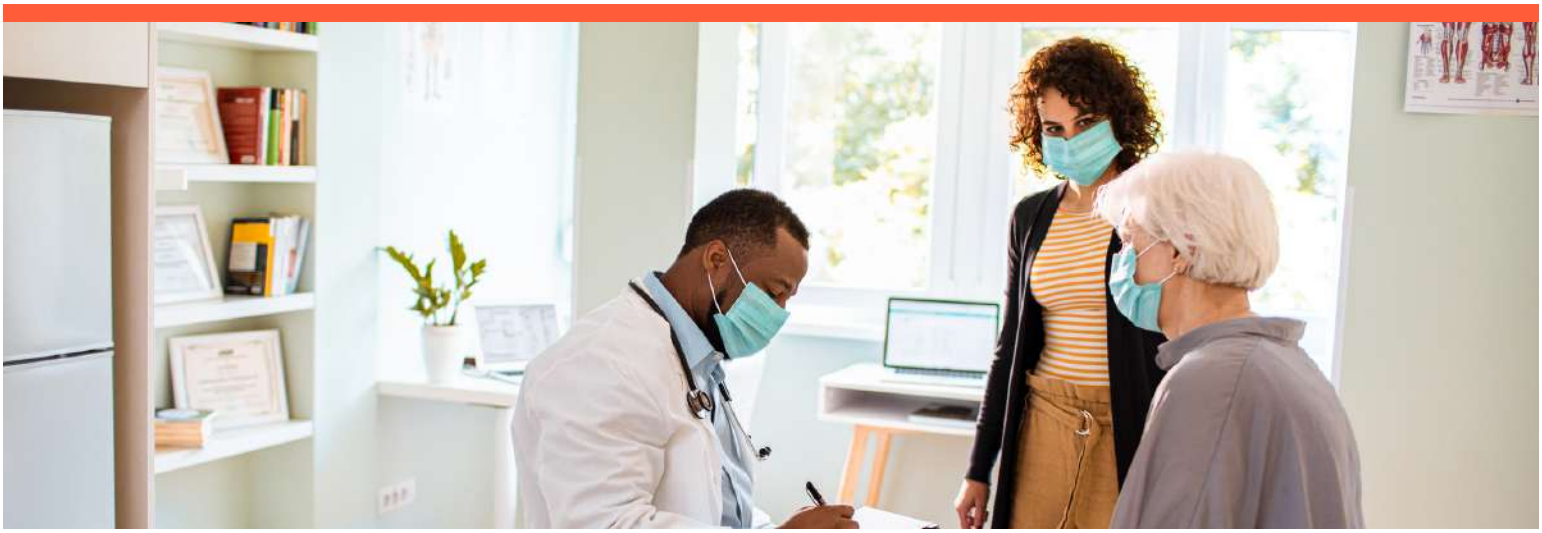
What is a Health Maintenance Organization (HMO)?
An HMO gives you access to certain doctors and hospitals within its network. A network is made up of providers that have agreed to lower their rates for plan members and also meet quality standards. But unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO's network.

What is a Preferred Provider Organization (PPO)?
A PPO is a group of hospitals and physicians that contract on a fee-for-service basis with insurance companies to provide comprehensive medical service.

What is In-Network?
Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members at a set rate. Health care providers are not able to charge insureds more than the negotiated fee set by the insurance provider.

What is Out-of-Network?
Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers, which usually results in a greater out-of-pocket expense to the patient.

What is an Explanation of Benefits (EOB)?
An EOB is a description your insurance carrier sends to you explaining the health care benefits that you received and the services for which your health care provider has requested payment.



DENTAL COVERAGE

The following chart summarizes the benefits for the dental plans offered to all eligible employees of Orange County Academy of Sciemces and Art. As an eligible employee, you may choose to enroll in one of the following plans.

LEARN MORE: Please note that the chart below is intended for comparison purposes only. For a comprehensive listing of what is covered and not covered under each plan, please refer to the Evidence of Coverage booklet.

	Anthem HMO 2000A	Anthem Gold PPO 100/90/60	
		In-Network	Out-of-Network*
Benefit Description & Procedure Code			
Annual Deductible Individual/Family	None	$50 / $150 (Waived for Preventive Care)	$50 / $150
Annual Maximum Benefit ** Per Member Enrolled	None	$1,500	$1,500
Preventive & Diagnostic Services			
Prophylaxis (Cleaning) D1110	$0 Copay	Plan 100%; You 0%	Plan 100%; You 0%
Bitewing X-rays D0272	$0 Copay	Plan 100%; You 0%	Plan 100%; You 0%
Basic Services			
Amalgam Restoration (Filling) one surface D2140	$0 Copay	Plan 90%; You 10%	Plan 80%; You 20%
Endodontics Therapy (Root Canal) D3310	$90 Copay	Plan 90%; You 10%	Plan 80%; You 20%
Major Services			
Porcelain Crown D2750	$175 Copay*	Plan 60%; You 40%	Plan 50%; You 50%
Dentures D5110	$175 Copay	Plan 60%; You 40%	Plan 50%; You 50%
Orthodontic Benefits			
Orthodontic Benefit (Adult/Child(ren))	$1,895 adult / $1,695 Child	Plan 50%; You 50%	Plan 50%; You 50%
Lifetime Maximum Benefit	$1,895 adult / $1,695 Child	$1,500 (child only)	$1,500 (child only)

Only partial coverage details provided above. For full in-network and out-of-network plan details, please review the benefit summaries and Evidence of Coverage booklets.

*Members are subject to charges above the allowed out-of-network (OON) reimbursable charge since services are rendered by non-contracted providers. This is called balance billing.

**Annual Maximum is based on the calendar year.

PLEASE NOTE:

- If you elect Dental HMO (DHMO) coverage, you must select a contracted dentist from the DHMO Provider list. All care must be provided by the primary dentist.
- The Dental PPO (DPPO) plan provides you with the flexibility to receive services with a dental professional In-Network or Out-of-Network. As a suggestion, prior to receiving services outside of preventive care, ask your dentist to request a predetermination or estimate on the planned services with Anthem. This will allow you to see what services will be performed, what will be covered by your plan and what amount you will be responsible for.

VISION COVERAGE

The following chart summarizes the benefits for the vision plan offered to all eligible employees of Orange County Academy of Sciences and Art.

LEARN MORE: Please note that the chart below is intended for comparison purposes only and provides only a brief overview of the most common benefits covered under your plan. For a comprehensive listing of what is covered and not covered (limitations and exclusions) under each plan, please refer to the Evidence of Coverage booklet.

	Anthem Blue View Vision	
	In-Network	Out-of-Network
Basic Eye Exam	$10 Copay	Plan pays up to $42
Frames	$130 Allowance + 20% off the remaining balance	Plan pays up to $45
Single Vision Lenses	$25 Copay	Plan pays up to $40
Bifocal Lenses	$25 Copay	Plan pays up to $60
Trifocal Lenses	$25 Copay	Plan pays up to $80
Medically Necessary Contacts (in lieu of frames)	Covered 100%	Plan pays up to $210
Elective Disposable Contact Lenses (in lieu of frames)	$130 Allowance	Plan pays up to $60
Eye Exam Benefit Frequency	Once every calendar year	Same as In-Network
Frame Benefit Frequency	Once every other calendar year	Same as In-Network
Lenses Benefit Frequency	Once every calendar year	Same as In-Network

LIFE & AD&D COVERAGE

Basic Life and AD&D Coverage

Orange County Academy of Sciences and Art provides all active employees with basic life insurance and accidental death and dismemberment (AD&D) coverage through Anthem. This benefit provides valuable income protection in the event that you suffer a severe accident or loss of life. An accelerated death benefit is also included in this policy. You must name a beneficiary for your Life and AD&D benefits. Beneficiary changes can be done at any time during the plan year.

EMPLOYER PROVIDED LIFE INSURANCE	EMPLOYER PROVIDED ACCIDENTAL DEATH & DISMEMBERMENT
$50,000	Same as basic life

Your benefit may reduce due to age. You will still have benefits as your age increases, but they will reduce according to the schedule in your Certificate.

Orange County Academy of Sciences and Art offers Short Term Disability (STD) through Unum. These coverages provide financial assistance if you are unable to work for an extended period of time due to an illness or injury. Below are key highlights of the plan(s).

Voluntary Short-Term Disability

	STD Plan Highlights
Coverage Option	Up to 40% of monthly covered earnings
Elimination Period	7 Days
Maximum Benefit	$5,000 Monthly
Maximum Benefit Duration	6 Months
Pre-existing Conditions	Does Not Apply

Supplemental Term Life and AD&D Coverage - New Benefit

As an employee of Orange County Academy of Sciences and Art, you have the option of purchasing additional life and AD&D coverage through Anthem. This voluntary policy enables you to purchase coverage for yourself and qualified dependents. When you enroll yourself and your dependents in this benefit, you pay the full cost through post-tax payroll deductions. Please note that elections made for Life coverage must match AD&D elections.

	Employee	Spouse/DP	Child(ren)
Coverage Option	Increments of $10,000 to a maximum of the lesser of 5x salary or $300,000	Increments of $5,000, to a maximum of $150,000 up to 50% of the Employee's Voluntary Life Amount	Increments of $5,000, to a maximum of $15,000 up to 50% of the Employee's Voluntary Life Amount
Guaranteed Issue Amount	$100,000	$30,000	$15,000
Maximum Amount	$300,000	$150,000	$15,000

Evidence of Insurability (EOI) Health Information is required for all benefit election amounts. Guaranteed Issue will apply only if the minimum participation of 9 enrolled lives is met.

Employee Assistance Program
Service Summary
EAP with MyStrength

Anthem

Available 24/7, 365 days a year

Everything you share is confidential.*

When you need help meeting life's challenges, the Anthem Employee Assistance Program (EAP) is here for you and your household members. Check out some of the services we offer — at no cost to you:

Counseling

- Up to 3 visits per issue
- Face-to-face counseling or online visits via LiveHealth Online
- Can call EAP or use the online Member Center to initiate services

Legal consultation

- 30-minute phone or in-person meeting
- Discounted fees to retain a lawyer
- Online resources, including free legal forms, seminars and a library of articles

Financial consultation

- Phone meeting with financial professionals
- Consultation available during regular business hours — no time limits or appointments needed
- Online resources, including articles, calculators and budgeting tools

ID recovery

- Identity theft risk level checked by specialists
- Help with reporting to consumer credit agencies
- Assistance filling out paperwork and negotiating with creditors

myStrength

- Online "health club for your mind"
- E-learning modules and mood trackers
- Library of videos, articles and inspirational quotes
- Supports development of personal action plans

Dependent care and daily living resources

- Information available on child care, adoption, summer camps, college placement, elder care and assisted living through the EAP website
- For help with everyday needs, like pet sitting, relocation resources and more

Other anthemEAP.com resources

- Well-being articles, podcasts and monthly webinars
- Self-assessment tools for depression, anxiety, relationships, alcohol use, eating habits and more

Crisis consultation

- Toll-free number for emergencies
- Round-the-clock help available
- Critical event support online to help with planning, coping and recovery resources when tragedy strikes

Need help? Give EAP a try today.

Call us at **800-999-7222**, use our Sydney Health app, or go to **anthemEAP.com** and enter your company code: My EAP CA.

* In accordance with federal and state law, and professional ethical standards. This document is for general informational purposes. Check with your employer for specific information about benefits, limitations and exclusions.

Language Access Services – (TTY/TDD: 711)
Spanish – Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.
Chinese – 您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。

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unum
Better benefits at work.

ORANGE COUNTY ACADEMY OF SCIENCES AND ARTS

Learn more about your annual Wellness Benefit

Your Unum plan pays a Wellness Benefit for one wellness test each year.

With Unum's Wellness Benefit, you and other covered family members can receive a valuable incentive for important tests and screenings. Many of these tests are routinely performed, so it's easy to take advantage of this benefit.

Your Critical Illness wellness benefit is $50.

Your Accident wellness benefit is $50.

Your Hospital wellness benefit is $50.

Most common tests and screenings	
• Blood test for triglycerides • Fasting blood glucose test • Mammography	• Pap smear • Serum cholesterol test to determine HDL and LDL levels

Other tests and screenings include	
• Bone marrow aspiration or biopsy • CA 15-3 (blood test for breast cancer • CA-125 (blood test for ovarian cancer) • CEA (blood test for colon cancer) • Carotid Doppler • Chest X-ray • Echocardiogram • Electrocardiogram • Fasting plasma glucose (FPG) • Flexible sigmoidoscopy	• Hemoglobin A 1C (HbA1c) • Hemoccult stool analysis • PSA (blood test for prostate cancer) • Serum protein electrophoresis (blood test for myeloma) • Skin cancer biopsy • Stress test on bicycle or treadmill • Thermography • Thin prep pap test • Two-hour post-load plasma glucose • Colonoscopy

Each year, you can earn a valuable incentive just for taking care of your health. And so can each of your covered family members.

It's easy to file a claim.

You can receive a benefit for tests that are performed after your initial coverage date. **Follow these simple steps:**

1

File your claim online with a one-time registration on **unum.com,** by mail or over the phone.

Simply call **1-800-635-5597** to learn more.

2

You will need to provide the following:

- First and last names of the **employee** and **claimant** (the employee might not be the claimant)
- Employee's **Social Security number** or **policy number**
- **Name** and **date** of the test
- Name of **physician** and the **facility** where the test was performed.

For more information, please contact your HR representative.

Unum will pay Wellness benefits for all eligible policies according to policy terms.

THESE POLICIES OFFER LIMITED BENEFITS

The policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. See the actual policy or your Unum representative for specific provisions and details of availability.

Underwritten by: Unum Life Insurance Company of America, Portland, Maine;
In New York, underwritten by: First Unum Life Insurance Company, New York, New York

unum.com

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSA)

Orange County Academy of Sciences and Art is pleased to offer employees a Flexible Spending Account (FSA) program. FSAs allow employees to set aside pre-tax dollars for qualified healthcare and/or dependent care expenses. The money that is deposited into your FSA comes directly from your gross pay, which reduces your taxable income. Enrollment in one or both of these accounts is optional. Benefit-eligible employees have the option to set aside funds into the following types of FSA:

General Purpose Healthcare FSA:

A Healthcare FSA allows you to use pre-tax dollars from your paycheck for eligible medical, dental and vision expenses incurred by you, your spouse and your tax dependents. In order for your expenses to qualify for reimbursement from your FSA they must be considered "qualified expenses" as deemed by the IRS. IRS publication 502 lists all qualified expenses including things such as; office visit copays, coinsurance payments, braces, eye exams, and much more. Please note cosmetic procedures are not considered FSA-qualified expenses. Paying for qualified medical expenses using this tax-free money can save you money! For the 2023 plan year, the maximum amount you can contribute into your healthcare FSA is $3,050.

Dependent Care FSA:

Dependent care expenses that enable you (and your spouse, if applicable) to go to work and/or school full-time are eligible for reimbursement using tax-free money from your Dependent Care FSA (DCFSA). For expenses to qualify under this FSA, they must be related to the custodial care of your dependent(s) and must be incurred in order for you/your spouse to work. Schooling/tuition or the expenses for sending your child to an overnight camp are not reimbursable through the account. Additionally, payments made to one of your tax dependents, including your spouse or dependent child under the age of 19, are not reimbursable. For the 2023 plan year, the maximum amount you can contribute into your dependent care FSA is $5,000 per household (or $2,500 if married and filing separately).

Who qualifies as a dependent?

- **Your federal tax dependent who is under the age of 13 (i.e. age 12 and under)**
- **Your federal tax dependent (including your spouse) who is physically or mentally incapable of caring for him/herself**

Reimbursement from your DCFSA is easy! Download a reimbursement request form from www.goigoe.com and complete all sections. When complete, attach your back up documentation and send your request to IGOE. Once approved, reimbursement will be issued up to the available cash balance in your DFSA. Reimbursements are released on specific dates scheduled by your employer. Please review your Plan Highlights for more specific information on reimbursement release dates.

If you are not able to use all of the money you set aside, it cannot be returned to you at the end of the plan year. How do you avoid that? It's simple! Set your election by only putting aside enough money to cover expected day care expenses.

EMPLOYEE CONTRIBUTIONS

	Monthly Payroll Deductions			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical				
Anthem HMO	Rates are age-banded. Please check your Ease portal for more information.			
Kaiser HMO				
Anthem PPO				

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Dental & Vision				
Anthem Dental DHMO	$1.42	$13.75	$29.60	$29.60
Anthem Dental DPPO	$36.36	$85.52	$104.12	$160.96
Anthem Vision	$1.28	$8.42	$7.32	$14.82

Enrollment Checklist

- ☐ Gather Social Security numbers and dates of birth for you and your qualified dependents whom you want to enroll. Choose the plans and coverage levels that best meet your needs. Take time to review the benefit outlines provided in this guide. This will help you understand the plans that are offered and how they may fit your lifestyle and budget.
- ☐ Make sure that your family doctor(s) and dentist(s) are covered by the plans you have chosen.
- ☐ Decide how much to contribute to your Flexible Spending Accounts (FSAs) to help save on taxes while paying for qualified healthcare and dependent care.

This newsletter highlights the main features of the Orange County Academy of Sciences and Art benefit plan. It is intended to help you choose the benefits that are best for you. This newsletter does not include all plan rules and details. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this newsletter and the legal plan documents, the plan documents are the final authority. Orange County Academy of Sciences and Art reserves the right to change or discontinue its benefit plans at any time.

Carrier Contact Information

Administrator	Benefit	Phone	Website
Anthem Blue Cross	**Medical HMO & PPO**	**(800) 331-1476**	**www.anthem.com**
Kaiser Permanente	**Medical HMO**	**(800) 788-0710**	**www.kp.org**
Anthem Blue Cross	**Dental**	**(800) 331-1476**	**www.anthem.com**
Anthem Blue Cross	**Vision**	**(800) 331-1476**	**www.anthem.com**
Igoe	**FSA**	**(800) 633-8818**	**www.goigoe.com**
Anthem Blue Cross	**Basic Life & AD&D + Supp Life**	**(800) 331-1476**	**www.anthem.com**
UNUM	**Short-Term Disability**	**(800) 227-4165**	**www.unum.com**
UNUM	**Accident, Critical Illness, & Hospital**	**(800) 227-4165**	**www.unum.com**

Important Notices

Notice: Special Enrollment Rights

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

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

Notice: The Newborns' and Mothers' Health Protection Act (NMHPA)

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice: Woman's Health and Cancer Rights Act (WHCRA)

Did 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 reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the end of these notices.

Notice: Consolidated Omnibus Budget Reconciliation Act (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."**

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 (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 the contact person shown at the end of these notices.

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 (for fully insured plans issued in California, coverage generally last for 36 months). 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.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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 employees, after the Medicare initial enrollment period, you have 8-month special enrollment period 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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact information at the end of these notices. 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.

Notice: Uniformed Services Employment and Reemployment Rights Act (USERRA)

Under the Uniformed Services Employment Reemployment Rights Act of 1994 (USERRA), employees are provided with broad protection in terms of their reemployment upon completion of military service.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- **You ensure that your employer receives advance written or verbal notice of your service;**
- **You have five years or less of cumulative service in the uniformed services while with that particular employer;**
- **You return to work or apply for reemployment in a timely manner after conclusion of service; and**
- **You have not been separated from service with a disqualifying discharge or under other than honorable conditions.**

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- **Are a past or present member of the uniformed service;**
- **Have applied for membership in the uniformed service; or**
- **Are obligated to serve in the uniformed service;**

then an employer may not deny you:

- **Initial employment;**
- **Reemployment;**
- **Retention in employment;**
- **Promotion; or**
- **Any benefit of employment**

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in

HEALTH INSURANCE PROTECTION

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at (866) 4-USA-DOL or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm.**
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

Notice: 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, **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, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – MEDICAID
WEBSITE: http://www.myalhipp.com **PHONE: (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: (866) 251-4861** **EMAIL: CustomerService@MyAKHIPP.com** **MEDICAID ELIGIBILITY:** **WEBSITE: https://health.alaska.gov/dpa/Pages/default.aspx**	**HEALTH FIRST COLORADO WEBSITE: https://healthfirstcolorado.com/** **HEALTH FIRST COLORADO MEMBER CONTACT CENTER:** **(800) 221-3943 / STATE RELAY 711** **CHP+: https://hcpf.colorado.gov/child-health-plan-plus** **CHP+CUSTOMER SERVICE: (800) 359-1991 / STATE RELAY 711** **HEALTH INSURANCE BUY-IN PROGRAM (HIBI):** **https://www.mycohibi.com/** **HIBI CUSTOMER SERVICE: (855) 692-6442**
ARKANSAS – MEDICAID	**FLORIDA – MEDICAID**
WEBSITE: http://myarhipp.com/ **PHONE: (855) MyARHIPP (855-692-7447)**	**WEBSITE:** **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** **PHONE: (877) 357-3268**
GEORGIA – MEDICAID	**LOUISIANA – MEDICAID**
GA HIPP WEBSITE: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** **PHONE: (678) 564-1162, Press 1** **GA CHIPRA WEBSITE:** **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**	**WEBSITE: www.medicaid.la.gov or www.ldh.la.gov/lahipp** **MEDICAID HOTLINE: (888) 342-6207** **LAHIPP PHONE: (855) 618-5488 (LaHIPP)**

INDIANA – MEDICAID	MAINE – 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	ENROLLMENT WEBSITE: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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
IOWA – MEDICAID AND CHIP (HAWKI)	**MASSACHUSETTS – MEDICAID AND CHIP**
MEDICAID WEBSITE: https://dhs.iowa.gov/ime/members PHONE: (800) 338-8366 HAWKI WEBSITE: http://dhs.iowa.gov/hawki PHONE: (800) 257-8563 HIPP WEBSITE: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	WEBSITE: https://www.mass.gov/masshealth/pa PHONE: (800) 862-4840 TTY: (617) 866-8102
KANSAS – MEDICAID	**MINNESOTA – MEDICAID**
WEBSITE: https://www.kancare.ks.gov/ PHONE: (800) 792-4884 HIPP PHONE: (800) 766-9012	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
KENTUCKY – MEDICAID	**MISSOURI – 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	WEBSITE: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm PHONE: (573) 751-2005
MONTANA – MEDICAID	**NORTH DAKOTA – MEDICAID**
WEBSITE: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP PHONE: (800) 694-3084 EMAIL: HHSHIPPProgram@mt.gov	WEBSITE: http://www.nd.gov/dhs/services/medicalserv/medicaid/ PHONE: (844) 854-4825
NEBRASKA – MEDICAID	**OKLAHOMA – MEDICAID AND CHIP**
WEBSITE: http://www.ACCESSNebraska.ne.gov PHONE: (855) 632-7633 LINCOLN: (402) 473-7000 OMAHA: (402) 595-1178	WEBSITE: http://www.insureoklahoma.org PHONE: (888) 365-3742
NEVADA – MEDICAID	**OREGON – MEDICAID**
MEDICAID WEBSITE: https://dhcfp.nv.gov/ MEDICAID PHONE: (800) 992-0900	WEBSITE: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html PHONE: (800) 699-9075
NEW HAMPSHIRE – MEDICAID	**PENNSYLVANIA – MEDICAID**
WEBSITE: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program PHONE: (603) 271-5218 TOLL FREE NUMBER FOR THE HIPP PROGRAM: (800) 852-3345 Ext. 5218	WEBSITE: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx PHONE: (800) 692-7462 WEBSITE: Children's Health Insurance Program (CHIP) (pa.gov) PHONE: (800) 986-KIDS (5437)
NEW JERSEY – MEDICAID AND CHIP	**RHODE ISLAND – 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	WEBSITE: http://www.eohhs.ri.gov/ PHONE: (855) 697-4347 or (401) 462-0311 (Direct Rite Share Line)

NEW YORK – MEDICAID	SOUTH CAROLINA – MEDICAID
WEBSITE: https://www.health.ny.gov/health_care/medicaid/ **PHONE: (800) 541-2831**	**WEBSITE: https://www.scdhhs.gov** **PHONE: (888) 549-0820**
NORTH CAROLINA – MEDICAID	**SOUTH DAKOTA - MEDICAID**
WEBSITE: https://medicaid.ncdhhs.gov/ **PHONE: (919) 855-4100**	**WEBSITE: http://dss.sd.gov** **PHONE: (888) 828-0059**
TEXAS – MEDICAID	**WASHINGTON – MEDICAID**
WEBSITE: http://gethipptexas.com/ **PHONE: (800) 440-0493**	**WEBSITE: https://www.hca.wa.gov/** **PHONE: (800) 562-3022**
UTAH – MEDICAID AND CHIP	**WEST VIRGINIA – MEDICAID AND CHIP**
MEDICAID WEBSITE: https://medicaid.utah.gov/ **CHIP WEBSITE: http://health.utah.gov/chip** **PHONE: (877) 543-7669**	**WEBSITE: https://dhhr.wv.gov/bms/** **http://mywvhipp.com/** **MEDICAID PHONE: (304) 558-1700** **CHIP PHONE: (855) MyWVHIPP (699-8447)**
VERMONT– MEDICAID	**WISCONSIN – MEDICAID AND CHIP**
WEBSITE: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access **PHONE: (800) 250-8427**	**WEBSITE:** **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** **PHONE: (800) 362-3002**
VIRGINIA – MEDICAID AND CHIP	**WYOMING – MEDICAID**
WEBSITE: https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ **MEDICAID PHONE & CHIP PHONE: (800) 432-5924**	**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, 2024, 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

OMB Control Number 1210-0137 (Expires: 1/31/2026)

Notice (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): Patient Protection –Primary Care Designation (HMO)

Your group health plan 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, your health insurer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, see the contact information at the end of these notices.

Notice (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): Patient Protection –Obstetrics & Gynecological care (HMO)

You do not need prior authorization from your group health plan 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, see the contact information at the end of these notices.

NOTICE: Grandfathered Plans

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

For more information, contact:
Name: Dot Blanchi
Title: Director of Admissions and Operations
Address: 30011 Ivy Glenn Dr., Suite 125 Laguna Niguel, CA 92677
Telephone Number: (949) 269-3293
Other contact information: dmblanchi@ocasa.org

Notice: HIPAA Notice of Privacy Practice

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights	**You have the right to:** • Get a copy of your health and claims records • Correct your health and claims records • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated
Your Choices	**You have some choices in the way that we use and share information as we:** • Answer coverage questions from your family and friends • Provide disaster relief • Market our services and sell your information
Our Uses and Disclosures	**We may use and share your information as we:** • Help manage the health care treatment you receive • Tun our organization • Pay for your health services • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests and work with a medical examiner or funeral director • Address workers' compensation, law enforcement and other government requests • Respond to lawsuits and legal action

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. • We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 9. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what to share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information.
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your Plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect or domestic partner • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research
Comply with the law	• We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	• For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

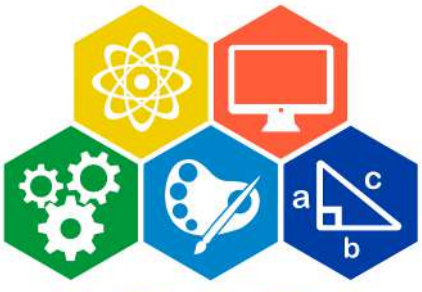
• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective date of this Notice

January 1, 2024



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