

# 2025

## Benefits Information Guide



## Guidelines/Evidence of Coverage

The benefit summaries listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 32 for more details.

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The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.



# Discover Your Benefits

*Let's explore your benefit plan options, programs and resources.*

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Access your benefits from anywhere, anytime!



## iNGAGED

Available for iOS and Android mobile devices, the iNGAGED app makes checking your health and benefits information easier than ever!

With iNGAGED, you can view our company's benefit plans and resources, access policy information and group numbers, quickly contact an insurance carrier, keep up with important benefit plan announcements, and store images of your ID cards directly in the app.

Download the "iNGAGED Benefits" app from the App Store or Google Play or go to [www.ingagedbenefits.com/login](http://www.ingagedbenefits.com/login) and use company code PUSD to login.





## Eligibility & Enrollment





# Eligibility & Enrollment

*Time to answer some questions...*

## Who can enroll?

All Benefits-Eligible employees are required to be covered under the District's Health & Welfare. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) (hereinafter referred to as "registered domestic partner") and/or eligible children.

## When does coverage begin?

Employees are eligible for insurance coverage upon being hired shall be entitled to health and welfare benefits as follows:

- (1) Employees hired between the 1<sup>st</sup> and 15<sup>th</sup> of the month will have coverage effective beginning the first of the following month
- (2) Employees hired between the 16<sup>th</sup> and 31<sup>st</sup> of the month will have coverage effective the beginning of the second month.

Your enrollment choices remain in effect through the end of the benefits plan year, January 1, 2025 – December 31, 2025. If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status event during the plan year. Please check with your plan administrator and your Section 125 plan document on any applicable status change events that would allow you to make a mid-year election change.



## How do I get started with my enrollment?



Paramount Unified School District provides its employees with an online benefits enrollment platform through BenTek's Employee Benefits Center (EBC). The EBC provides benefits-eligible employees the ability to select or change their insurance benefits online during the annual open enrollment period, new hire orientation and for qualifying events.

The EBC is accessible 24 hours a day at any time during the year. Employees may log in, review comprehensive benefit plan information, print an outline of benefit elections for all covered individuals, access forms and carrier links, report a qualifying life event and review or change life insurance benefit designations.

## To Access BenTek Using a Mobile Device

Scan the QR Code to access



## To Access the Employee Benefits Center:

1. Log on to [www.mybentek.com/paramount](http://www.mybentek.com/paramount)
2. Sign-in by using your previously created username and password or follow the instructions to set up your own username and password. If you have forgotten your username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
3. Once logged on, navigate to the menu in order to review current elections, learn about your options, and make any elections or changes.

## What if my needs change during the year?

You are permitted to make changes to your benefits after the open enrollment period if you have a change in status event as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the status change event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's loss or gain of coverage through our organization or another employer.
- An employee (1) was expected to average at least 30 hours of service per week, (2) has a change in employment status where he/she will reasonably be expected to average less than 30 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage).
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange due to open enrollment or special enrollment period, and coverage is effective no later than the day immediately following the revocation of your employer-sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of status change events, please contact your Human Resource team.

## Do I have to enroll?

You are eligible to opt-out of the district's Health & Welfare only if you and your spouse are both benefits-eligible employees of the Paramount Unified School District. You must be a covered dependent under your spouse's coverage.







## Cost Breakdown



# Cost Breakdown

*All of your rates in one place.*

The rates below are effective January 1, 2025 – December 31, 2025

## Medical, Dental and Life Rates

Certificated	Medical		Dental		Life	
	Kaiser	Blue Cross	Delta Dental		Life	
Tenthly Premium	\$ 923.75	\$ 1,221.17	\$ 164.03	\$	\$	7.60
District Contribution	\$ 649.97	\$ 947.39	\$ 164.03	\$	\$	7.60
<b>Employee Only</b>	<b>\$ 273.78</b>	<b>\$ 273.78</b>	<b>\$ -</b>	<b>\$</b>	<b>\$</b>	<b>-</b>
Tenthly Premium	\$ 1,847.48	\$ 2,313.65	\$ 164.03	\$	\$	7.60
District Contribution	\$ 1,473.70	\$ 1,939.87	\$ 164.03	\$	\$	7.60
<b>Employee +1</b>	<b>\$ 373.78</b>	<b>\$ 373.78</b>	<b>\$ -</b>	<b>\$</b>	<b>\$</b>	<b>-</b>
Tenthly Premium	\$ 2,614.20	\$ 3,196.69	\$ 164.03	\$	\$	7.60
District Contribution	\$ 2,164.60	\$ 2,747.09	\$ 164.03	\$	\$	7.60
<b>Employee + Family</b>	<b>\$ 449.60</b>	<b>\$ 449.60</b>				

Classified & Board	Medical		Dental		Life	
	Kaiser	Blue Cross	Delta Dental		Life	
Tenthly Premium	\$ 923.75	\$ 1,221.17	\$ 164.03	\$	\$	7.60
District Contribution	\$ 629.76	\$ 927.18	\$ 164.03	\$	\$	7.60
<b>Employee Only</b>	<b>\$ 293.99</b>	<b>\$ 293.99</b>	<b>\$ -</b>	<b>\$</b>	<b>\$</b>	<b>-</b>
Tenthly Premium	\$ 1,847.48	\$ 2,313.65	\$ 164.03	\$	\$	7.60
District Contribution	\$ 1,540.07	\$ 2,006.24	\$ 164.03	\$	\$	7.60
<b>Employee +1</b>	<b>\$ 307.41</b>	<b>\$ 307.41</b>	<b>\$ -</b>	<b>\$</b>	<b>\$</b>	<b>-</b>
Tenthly Premium	\$ 2,614.20	\$ 3,196.69	\$ 164.03	\$	\$	7.60
District Contribution	\$ 2,299.33	\$ 2,881.82	\$ 164.03	\$	\$	7.60
<b>Employee + Family</b>	<b>\$ 314.87</b>	<b>\$ 314.87</b>	<b>\$ -</b>	<b>\$</b>	<b>\$</b>	<b>-</b>

Management & Confidential	Medical		Dental		Life	
	Kaiser	Blue Cross	Delta Dental		Life	
Tenthly Premium	\$ 923.75	\$ 1,221.17	\$ 164.03	\$	\$	7.60
District Contribution	\$ 659.76	\$ 957.18	\$ 164.03	\$	\$	7.60
<b>Employee Only</b>	<b>\$ 263.99</b>	<b>\$ 263.99</b>	<b>\$ -</b>	<b>\$</b>	<b>\$</b>	<b>-</b>
Tenthly Premium	\$ 1,847.48	\$ 2,313.65	\$ 164.03	\$	\$	7.60
District Contribution	\$ 1,540.07	\$ 2,006.24	\$ 164.03	\$	\$	7.60
<b>Employee +1</b>	<b>\$ 307.41</b>	<b>\$ 307.41</b>	<b>\$ -</b>	<b>\$</b>	<b>\$</b>	<b>-</b>
Tenthly Premium	\$ 2,614.20	\$ 3,196.69	\$ 164.03	\$	\$	7.60
District Contribution	\$ 2,299.33	\$ 2,881.82	\$ 164.03	\$	\$	7.60
<b>Employee + Family</b>	<b>\$ 314.87</b>	<b>\$ 314.87</b>	<b>\$ -</b>	<b>\$</b>	<b>\$</b>	<b>-</b>





Medical



# Medical

*Which plan type is right for you?*

## HMO

A Health Maintenance Organization (HMO) Plan requires you to select a Primary Care Physician (PCP) and your providers must be contracted with the HMO network. Out-of-network coverage is not available except in the case of an emergency.

### Advantages

Lower out-of-pocket costs.  
Care coordinated by PCP.

### Out-of-pocket costs

Both copays and coinsurance are generally a lower out-of-pocket expense than a PPO plan.

### Ideal if...

... you prefer a lower payroll deduction and are comfortable with a PCP directing your care.

### Finding a provider for Kaiser HMO:

1. Go to [kaiserpermanente.org](http://kaiserpermanente.org)
2. Click on Doctors & Locations
3. Select region: Southern or Northern California
4. Enter your Zip Code or Select a City
5. Click on Search
6. To locate a provider by phone: 800.464.4000

### Note:

Out-of-network services without proper PCP referral will not be covered.

## PPO

A Preferred Provider Organization (PPO) Plan contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Using providers that belong in the plan's network will provide a higher benefit, but you have the flexibility to see a provider outside the network, generally for an additional cost.

Broader choice of providers.  
No referrals required for specialists.

You'll be responsible for copays and coinsurance, but your deductible will be lower than the HDHP plan.

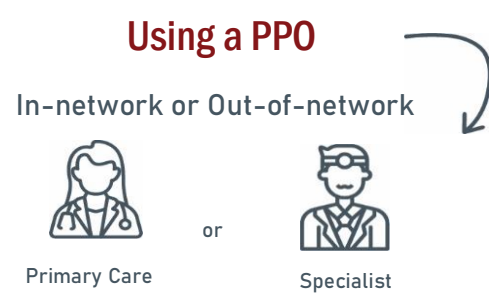
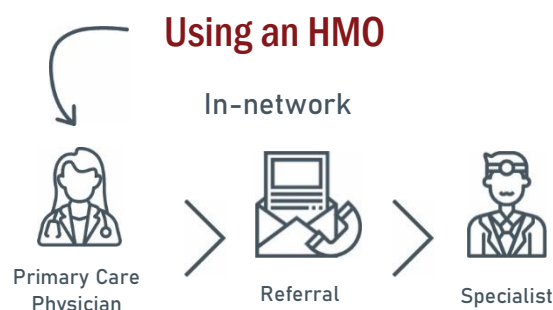
... you prefer flexibility and provider options, and if you're comfortable paying more out of your paycheck and less out of pocket for your deductible.

### Finding a provider for Anthem Blue Cross:

1. Go to [www.Anthem.com/CA](http://www.Anthem.com/CA)
2. In the top ribbon, select Find a Care
3. You may Search as a Member or Search as a Guest and select Continue
4. Select the following options:
5. Searching for: Medical
6. State: California
7. Type of Plan: Medical (Employer-Sponsored)
8. PPO Network: Blue Cross PPO (Prudent Buyer) – Large Group
9. Select the parameters that you'd like to search for and click Continue

You may choose in or out-of-network care. However, in-network care provides you a higher level of benefit.

Please note, the above examples are used for general illustrative purposes only. Please consult with Business Services for more specific information as it relates to your specific plan.





# Prescription Drug (Rx) Benefits

Many FDA-approved prescription medications are covered through the benefits program. Tiered prescription drug plans require varying levels of payment depending on the drug's tier.



**Generic formulary (Tier 1):** Generic drugs contain the same active ingredients as their brand-name counterparts but are less expensive.



**Brand name medications (Tier 2):** A brand-name medication can only be produced by one specified manufacturer and is proven to be the most effective in its class.



**Non-formulary prescriptions (Tier 3):** Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list. This is because there is an alternative proven to be just as effective and safe, but less costly. Ask your doctor or pharmacist for additional information regarding the generic option.



**Specialty prescriptions (Tier 4):** Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

For current versions of the prescription drug lists, go to [www.KP.org](http://www.KP.org) or [www.Navitus.com](http://www.Navitus.com)

Mail Order Prescriptions with Costco are available to Anthem Blue Cross PPO participants only.



## WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:

### Costco Pharmacy Retail Program

Want to save money on your prescription medications?

Take Advantage of Free Generic Medications at Costco:

1. Take your prescription for a generic medication to a Costco Pharmacy
2. Present the pharmacist with your insurance card
3. Get your generic medication with a **\$0 co-payment**  
(excluding some narcotic pain medications and some cough medications)

\*You do not have to be a Costco member to use their pharmacy services. Just tell the associate at the front door you are going to their pharmacy.



### Costco Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of purchasing your typical 30-day supply at a walk-in pharmacy.



### Navitus Mail Order through Costco (In-Network Only)

- Contraceptive Drugs & Devices: No Charge
- Tier 1 – Generic: \$25 Copay
- Tier 2 – Preferred Brand: \$45 Copay
- Tier 3 – Non-Preferred Brand: \$90 Copay

### Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores may offer less expensive prescriptions than others. By calling, you may determine which pharmacy provides the most competitive price.



### Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.

"I need specific medical care! How much does it cost?"

## Plan Highlights



	In-Network Only
<b>Annual Calendar Year Deductible</b>	
Individual	None
Family	None
<b>Maximum Calendar Year Out-of-pocket <sup>(1)</sup></b>	
Individual	\$1,500
Family	\$3,000
<b>Professional Services</b>	
Primary Care Physician (PCP)	\$10 per Visit
Specialist	\$10 per Visit
Telehealth Visit	No Charge
Preventive Care Exam	No Charge
Diagnostic X-ray and Lab	No Charge
Complex Diagnostics (MRI/CT Scan)	No Charge
<b>Hospital Services</b>	
Inpatient	No Charge
Outpatient Surgery	\$10 per procedure
Urgent Care	\$10 per Visit
Emergency Room	\$35 per Visit
<b>Mental Health &amp; Substance Abuse</b>	
Inpatient	No Charge
Outpatient	\$10 per individual Visit/\$5 per group Visit
<b>Vision</b>	
Eye Exam	No Charge
Glasses Every 24 Months	\$125 Allowance
<b>Retail Prescription Drugs (1-100 days' supply)</b>	
Tier 1	\$5 Copay
Tier 2	\$10 Copay
Tier 3	\$10 Copay
Tier 4	\$10 Copay

<sup>(1)</sup> Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

"I need specific medical care!  
How much does it cost?"



## Plan Highlights

	In-network	Out-of-network
<b>Annual Calendar Year Deductible</b>		
Individual	None	None
Family	None	None
<b>Maximum Calendar Year Out-of-pocket <sup>(1)</sup></b>		
Individual	\$1,000	No Limit
Family	\$3,000	No Limit
<b>Professional Services</b>		
Primary Care Physician (PCP)	\$0 Copay per Visit 1-3, then \$20 Copay per Visit 4+	See Footnote 2
Specialist	\$20 per Visit	See Footnote 2
Telehealth Visit	No Charge	No Charge
Preventive Care Exam	No Charge	Not Covered
Diagnostic X-ray and Lab	No Charge	Not Covered
Complex Diagnostics (MRI/CT Scan)	No Charge	See footnote 2 and 3
Manipulation Therapy	No Charge	Not Covered
Acupuncture Services (12 visits per benefit period)	No Charge	50% of maximum allowed amount (see footnote 2)
<b>Hospital Services</b>		
Inpatient	No Charge	All billed amounts exceeding \$600 a day
Outpatient Surgery	No Charge	All billed amounts exceeding \$350 a day
Urgent Care	\$20 per Visit	See footnote 2
Emergency Room	\$100 per Visit (waived if admitted)	\$100 per Visit (waived if admitted)
<b>Mental Health &amp; Substance Abuse</b>		
Inpatient	\$20 copay per visit	All billed amounts exceeding \$600 per day
Outpatient	No Charge	See footnote 3
<b>Retail Prescription Drugs (30-day supply)</b>		
Tier 1	\$10 Copay (\$0 at Costco)	Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an In-network provider.
Tier 2	\$20 Copay	
Tier 3	\$35 Copay	
Tier 4	Not Covered	
<b>Mail Order Prescription Drugs (90-day supply)</b>		
Tier 1	\$25 Copay	Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an In-network provider.
Tier 2	\$45 Copay	
Tier 3	\$90 Copay	
Tier 4	Not Covered	

- 1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.
- 2) When using Non-Network PPO Providers, members are responsible for any difference between the maximum allowed amount and actual charges, as well as any deductible & percentage copay.
- 3) The plan may pay for the following services and supplies up to the maximum number of days or visits and/or dollar maximum shown. When using non-network providers, the plan will pay the lesser of the benefit maximum or the maximum allowed amount. If the maximum allowed amount is less than the listed benefit maximum, the plan will not exceed the maximum allowed amount. Likewise, if the listed benefit maximum is less than the maximum allowed amount, the plan will not exceed the listed benefit maximum.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.



# P3 | Paramount Personal Physician

with  Providence

**Concierge-style, high caliber care  
at the work place**

## A+ CARE

The P<sup>3</sup> Wellness Center was created to deliver convenient onsite primary care services right at Paramount Unified School District. Benefits include:

- \$0 out of pocket for services provided at the P<sup>3</sup> Wellness Center
- Easy access with same day appointments. Please call first for availability
- Convenient location and hours of operation
- 24/7 access to secure messaging and access to your medical records
- Full time on site board certified physician

## Medical Services

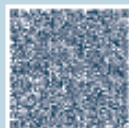
- |  |                    |
|--|--------------------|
| • Annual physicals   | • Acute illnesses  |
| • Blood draws  | • Minor injuries   |
| • Chronic condition management (hypertension, diabetes, etc) | • Vaccinations     |
| • Total Woman Care (No OB care)                              | • Skin procedures  |
|  | • Sports physicals |
|  | • Virtual visits   |

*The program allows PUSD employees, non-Medicare retirees and their dependents (over 6 years old), spouses or eligible domestic partners enrolled in the PUSD Anthem Blue Cross PPO plan access to a dedicated physician at the onsite wellness center.*

## MY CHART

- Message your care team
- Check-in for your appointments
- View test results the same time as your physician
- Renew prescriptions

**Scan this QR code  
with your smart-  
phone to sign up.**



## MEET YOUR DEDICATED PROVIDENCE PHYSICIAN

**Nicole Shweiri, M.D.**



Dr. Shweiri is board certified in family medicine, caring for both adults and children, and is a member of the American Academy of Family Physicians. She treats her patients with dignity, compassion and

respect, emphasizing lifestyle modifications and preventative measures to help them achieve optimum health and wellness. Dr. Shweiri treats acute illnesses and chronic conditions, performs dermatologic procedures, annual preventative exams, as well as skillful lifestyle coaching to deliver a lifetime of good health.



Parking in Northwest staff parking lot, entrance off of Downey Ave.

## P3 Wellness Center

8535 Contreras Street, Paramount, CA 90723  
(562) 408-1033 • [ParamountP3@stjoe.org](mailto:ParamountP3@stjoe.org)

## Hours of Operation

**Mon.** — 9 a.m. – 5:30 p.m.  
**Tues. – Fri.** — 7 a.m. – 4 p.m.

## COVID-19 UPDATE

The safety of you and your family is important to us. All visits to the wellness center will be by appointment only. If you are not feeling well, please call our office so we can determine the best way to serve you.





Dental  
Plan





# Dental Plan

*A smile is the nicest thing you can wear.*

## Using the PPO Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists. To determine whether your dentist is in or out of your insurance network, go to [www.deltadental.com](http://www.deltadental.com) and search the provider network, or call 866.499.3001.

"I need specific dental care! How much does it cost?"

Plan Highlights	Delta Dental PPO	
	In-network	Out-of-network
Calendar Year Deductible	None	None
Annual Maximum	\$2,500 per person	\$2,500 per person
Preventive	100%	100%
Basic Services	100%	100%
Major Services	70%	50%
Orthodontia Services	Not Covered	Not Covered
Dental Accident Benefit (separate \$1,000 maximum per person per calendar year)	100%	100%

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.







## Vision Plan





# Vision Plan

*Keep a clear focus on your sight.*

Vision coverage is offered by EyeMed as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit [www.eyemed.com](http://www.eyemed.com).

If you are enrolled in the Kaiser HMO Plan vision benefits are included within the plan.

**"I need specific vision care! How much does it cost?"**

## Plan Highlights

## EyeMed Vision PPO (with Anthem PPO Plan)

	In-network	Out-of-network
Exam – Every 12 months	\$10 copay	Up to \$40 copay
Lenses – Every 12 months		
Single	\$50 copay	Not Covered
Bifocal	\$70 copay	Not Covered
Trifocal	\$105 copay	Not Covered
Frames – Every 12 months	35% off retail price	Not Covered
Additional Pairs of Glasses*	40% off retail price	Not Covered
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	15% off retail price	Not Covered
Cosmetic	15% off retail price	Not Covered
LASIK	15% off retail price or 5% promo price	Not Covered

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

\* Frame, lenses, and lens options must be purchased in the same transaction to receive full discount



## Create a member account at [eyemed.com](http://eyemed.com)

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor—search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT  
PROVIDER  
NETWORK



LENSCRAFTERS

PEARLE  
VISION

OPTICAL





## Spending Accounts







# Spending Accounts

*Make your money work for you.*

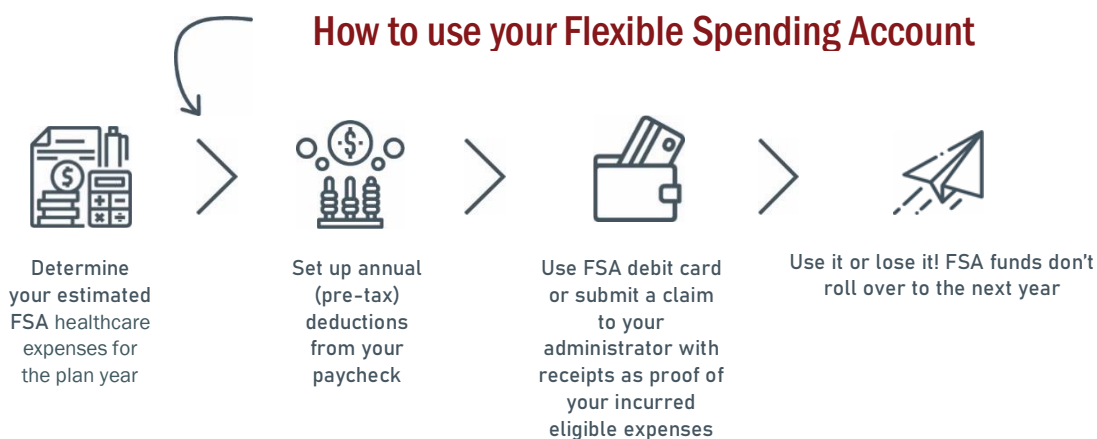
## Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible healthcare, and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
 Healthcare FSA	<ul style="list-style-type: none"><li>• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance.</li><li>• Maximum contribution for 2024 is \$3,200.</li></ul>
 Dependent Care FSA	<ul style="list-style-type: none"><li>• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves.</li><li>• Eligibility rules require that if you are married, your spouse needs to be working, looking for work or attending school full-time.</li><li>• Maximum contribution for 2024 is \$5,000.</li></ul>

For more details about using an FSA, contact Chard Snyder at 800.982.7715.

## How to use your Flexible Spending Account







Life &  
AD&D





# Life and AD&D

*Protection for your loved ones.*

## Basic Life and AD&D

In the event of your passing, life insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your accidental death & dismemberment (AD&D) coverage may apply.

Included in the District Health & Welfare benefits, the benefits outlined below are provided by Reliance Standard:

- Basic Life Insurance: \$50,000
- AD&D: \$50,000

## Reduction Schedule

For Active employees, benefits will be reduced by 40% at age 65; an additional 25% of the pre-age 65 amount at age 70, an additional 10% of the pre-age amount at age 75, and an additional 5% of the pre-age 65 amount at 80. If retired, benefits terminate at age 65.





## Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional life and AD&D coverage for you and/or your dependents is available on a voluntary basis through payroll deductions from Reliance Standard.



**For employees:**

Increments of \$10,000 up to a \$500,000.



**For your spouse:**

Increments of \$10,000 up to a \$500,000.



**For your child(ren):**

14 days old up to 6 months of age, \$1,000; 6 months old up to age 20, \$10,000.

\*Please note child coverage is to age 25 if Full-Time Student

If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

**Important Note:** If you do not elect optional life insurance when you are first eligible, you will be required to submit a health questionnaire to Reliance Standard, also known as Evidence of Insurability (EOI). An EOI will also be required if you wish to become insured for an amount greater than \$100,000 or if you wish to insure a dependent for an amount greater than \$20,000.



**Required! Are your beneficiaries up to date?**

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

You can change your beneficiary designation at any time.

You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.

To select or change your beneficiary, contact Business Services at 562.602.6029

### Cost of Voluntary Coverage

Age of Insured	Tenthly Rate per \$10,000
Under 30	\$1.30
30-34	\$1.50
35-39	\$1.90
40-44	\$2.30
45-49	\$3.60
50-54	\$5.30
55-59	\$7.60
60-64	\$12.20
65-69	\$20.60
70+	\$35.00

### Dependent Child Coverage

Benefit Amount for each child	Tenthly Rate for all children combined
\$2,500	\$0.50
\$5,000	\$1.00
\$7,500	\$1.50
\$10,000	\$2.00





Retirement





# Retirement

## Tax Sheltered Annuities

*Make retirement a reality, not a wish.*

## Your 403(b), 457(b) and/or Roth 403(b) Plan Options

Administered by SchoolsFirst Federal Credit Union, Paramount Unified School District offers you the opportunity to accumulate savings for your future. In addition to the 403(b) Plan, you can contribute to a 457(b) Plan and/or a Roth 403(b). Below is brief information regarding these plans. Any questions or concerns regarding your additional Retirement Savings Plan, call SchoolsFirst Federal Credit Union.

## Enrollment & Account Access

- To enroll online in the 403 (b), 457(b) and/or Roth 403(b) account plan, please visit [www.schoolsfirstfcu.org](http://www.schoolsfirstfcu.org)
- Check your 403 (b), 457(b) and/or Roth 403(b) account balance, view your contributions, change your investments and more by visiting [www.schoolsfirstfcu.org](http://www.schoolsfirstfcu.org). For login or password assistance please contact SchoolsFirst FCU at 800-462-8328 or 714-258-4000

Marsh & McLennan Insurance Agency LLC does not serve as advisor, broker-dealer or registered investment advisor for this plan. All of the terms and conditions of your plan are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.





## Employee Assistance Program (EAP)





# Employee Assistance Program (EAP)

*Your free and confidential go-to resource.*

We can all use an extra helping hand from time to time. Whether you need support with a personal relationship or professional challenge, or you're seeking guidance on a particular subject, the Employee Assistance Program (EAP) provides the tools you need to thrive. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Number of sessions	6 face-to-face sessions, online or by phone per year per member per incident
How to access	Phone or face-to-face sessions
Topics may include	<p>Mental Health Support:</p> <ul style="list-style-type: none"><li>• Marital, relationship or family problems.</li><li>• Bereavement or grief counseling.</li><li>• Substance abuse and recovery.</li></ul> <p>Community Support:</p> <ul style="list-style-type: none"><li>• Childcare and eldercare.</li><li>• Legal services and Identity theft.</li><li>• Financial support.</li><li>• Educational materials.</li></ul>
Who can utilize	All employees, dependents of employees, and members of your household



## Get in touch:

By phone: 800.999.7222.

Online: [www.anthemead.com](http://www.anthemead.com)

Website password: SISC.

## Feeling overwhelmed? Tap into the power of self-care.

Adult members can download 2 popular apps at [kp.org/selfcareapps](https://kp.org/selfcareapps)

These apps can help you build resilience, set goals, and take meaningful steps toward becoming healthier and happier. Choose the areas you want to focus on – including managing depression, reducing stress, improving sleep, and more.

- ☒ Evidence-based and proven effective
- ☒ Hand-picked by Kaiser Permanente physicians
- ☒ Confidential and easy to use



**Calm**

Calm is an app for daily use that uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality. With guided meditations, programs taught by world-renowned experts, sleep stories narrated by celebrities, mindful movement videos, and more, Calm offers something for everyone.



**myStrength**

myStrength offers personalized programs with interactive activities, daily health trackers to monitor and maintain your progress, in-the-moment coping tools, and more. It's designed to help you set goals and work toward them in ways that work for you – by making positive changes that support your mental, emotional, and overall well-being.

myStrength® is a trademark of Livongo Health, Inc., a wholly owned subsidiary of Teladoc Health, Inc.

Get the apps at [kp.org/selfcareapps](https://kp.org/selfcareapps).

The services described above are not covered under your health plan benefits and are not subject to the terms set forth in your Evidence of Coverage or other plan documents. These services may be discontinued at any time without notice.

Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 601 Union St., Suite 3100, Seattle, WA 98101



# Directory & Resources

Below, please find important contact information and resources for Paramount Unified School District.

## Information Regarding

## Contact Information

Enrollment & Eligibility	Phone	Web Address
Business Services – District Office		
• Yesica Alejandre, Health & Welfare Benefits	562.602.6029	<a href="mailto:YAlejandre@paramount.k12.ca.us">YAlejandre@paramount.k12.ca.us</a>
• Trish Rodriguez, Risk Management/Benefits	562.602.6027	<a href="mailto:PRodriguez@paramount.k12.ca.us">PRodriguez@paramount.k12.ca.us</a>
• Amelia Nuñez, Executive Assistant	562.602.6025	<a href="mailto:amnunez@paramount.k12.ca.us">amnunez@paramount.k12.ca.us</a>
Medical Coverage		
Kaiser Permanente HMO		<a href="http://www.kp.org">www.kp.org</a>
Anthem Blue Cross – PPO	800.464.4000	<a href="http://www.anthem.com/ca/sisc/">www.anthem.com/ca/sisc/</a>
• BlueCard (Out of State/World Wide)	800.825.5541	<a href="http://www.bcbs.com/bluecardworldwide">www.bcbs.com/bluecardworldwide</a>
• P3 (Paramount Personal Physician for Anthem Blue Cross members)	800.810.2583	<b>Email:</b> <a href="mailto:Paramountp3@stjoe.org">Paramountp3@stjoe.org</a>
• Navitus Pharmacy Services (Anthem Blue Cross members)	562.408.1033	<a href="http://www.navitus.com">www.navitus.com</a>
• American Specialty Health	866.333.2757	
• Anthem Employee Assistance Program	800.972.4226	<a href="http://www.ashcompanies.com">www.ashcompanies.com</a>
	800.999.7222	<a href="http://anthemEAP.com">anthemEAP.com</a>
Dental Coverage		
Delta Dental		
• PPO	866.499.3001	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
Vision Coverage with Anthem PPO		
EyeMed		
• PPO	866.804.0982	<a href="http://www.eyemed.com">www.eyemed.com</a>
Life, AD&D and Disability		
Reliance Standard		
• Life, AD&D	800.351.7500	<a href="http://www.reliancestandard.com">www.reliancestandard.com</a>
• Voluntary Life, AD&D		
Credit Unions		
SchoolsFirst Federal Credit Union	800.462.8328	<a href="http://www.schoolsfirstfcu.org">www.schoolsfirstfcu.org</a>
First Financial Credit Union	800.537.8491	<a href="http://www.ffcua.org">www.ffcua.org</a>
Mid Cities Credit Union	310.638.5147	<a href="http://www.midcitiescu.org">www.midcitiescu.org</a>
Supplemental Benefits (Voluntary Plans)		
American Fidelity		
• Accident, Critical Illness, Cancer, Disability, Hospital Indemnity, Life	800.365.9180	<a href="http://www.americanfidelity.com">www.americanfidelity.com</a>
The Standard (Available to CTA members only)	800.522.0406	<a href="http://www.standard.com">www.standard.com</a>
• Disability and Life		
Flexible Spending Accounts		
Chard Snyder FSA Vendor	800.982.7715	<a href="http://www.chard-snyder.com">www.chard-snyder.com</a>
Unions		
CSEA-California School Employees Association	800.988.6949	<a href="http://www.csea.com">www.csea.com</a>
CTA-California Teachers Association	562.942.7979	<a href="http://www.cta.org">www.cta.org</a>
Retirement Resources		
State Teachers Retirement System (STRS)	800.228.5453	<a href="http://www.calstrs.com">www.calstrs.com</a>
California Public Employees' Retirement System (CalPERS)	888.225.7377	<a href="http://www.calpers.ca.gov">www.calpers.ca.gov</a>

# Paramount Unified School District Health and Welfare

## Benefits Annual Notice Packet

For the January 1, 2025

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact Human Resources.

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## Medicare Part D Creditable Coverage Notice

### Important Notice from Paramount Unified School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Paramount Unified School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Paramount Unified School District has determined that the prescription drug coverage offered by the Blue Cross plan 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.

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#### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15<sup>th</sup> to December 7<sup>th</sup>. 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 while enrolled in Paramount Unified School District coverage as an active employee, please note that your Paramount Unified School District coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Paramount Unified School District coverage as a former employee.

You may also choose to drop your Paramount Unified School District coverage. If you do decide to join a Medicare drug plan and drop your current Paramount Unified School District coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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



Attention: Yesica Alejandre  
Benefits Technician  
Phone: (562) 602-6029  
Email: yalejandre@paramount.k12.ca.us

## HIPAA Special Enrollment Rights Notice

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

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Human Resources.

# HIPAA Notice of Privacy Practices

**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.**

Paramount Unified School District sponsors certain group health plan(s) (collectively, the “Plan” or “We”) to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the “Notice”) describes the legal obligations of Paramount Unified School District the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- (1) your past, present or future physical or mental health or condition;
- (2) the provision of health care to you; or
- (3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Paramount Unified School District you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

## **Contact Information**

If you have any questions about this Notice or about our privacy practices, please contact the Paramount Unified School District HIPAA Privacy Officer:

Attention: HIPAA Privacy Officer  
Paramount Unified School District  
Attention: Yesica Alejandre  
Benefits Technician  
Phone: (562) 602-6029  
Email: [yalejandre@paramount.k12.ca.us](mailto:yalejandre@paramount.k12.ca.us)

## **Effective Date**

This Notice as revised is effective October 1, 2025



## **Our Responsibilities**

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

## **How We May Use and Disclose Your Protected Health Information**

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

### **For Treatment**

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

### **For Payment**

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

### **For Health Care Operations**

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

### **To Business Associates**

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

### **As Required by Law**

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

### **To Avert a Serious Threat to Health or Safety**

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

### **To Plan Sponsors**

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

## **Special Situations**

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

### **Organ and Tissue Donation**

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

### **Military and Veterans**

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

### **Workers' Compensation**

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.



## **Public Health Risks**

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

## **Health Oversight Activities**

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

## **Lawsuits and Disputes**

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

## **Law Enforcement**

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

## **Coroners, Medical Examiners and Funeral Directors**

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

## **National Security and Intelligence Activities**

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

## **Inmates**

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

## **Research**

We may disclose your protected health information to researchers when:

- (1) the individual identifiers have been removed; or
- (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

## **Required Disclosures**

The following is a description of disclosures of your protected health information we are required to make.

### **Government Audits**

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

### **Disclosures to You**

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

### **Notification of a Breach.**

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

## **Other Disclosures**

### **Personal Representatives**

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- (3) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- (4) treating such person as your personal representative could endanger you; or
- (5) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

### **Spouses and Other Family Members**

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"),



and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

### **Authorizations**

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

## **Your Rights**

You have the following rights with respect to your protected health information:

### **Right to Inspect and Copy**

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

### **Right to Amend**

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

### **Right to an Accounting of Disclosures**

You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of

no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

### **Right to Request Restrictions**

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

### **Right to Request Confidential Communications**

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

### **Right to a Paper Copy of This Notice**

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see [Your Rights Under HIPAA](#).

### **Complaints**

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. 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 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html>.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.



## 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](http://www.healthcare.gov).

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://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](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –**

ALABAMA – Medicaid	ALASKA – Medicaid
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a>
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Fax: 916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid

<p>Health First Colorado Website:  <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a>  Health First Colorado Member Contact Center:  1-800-221-3943/ State Relay 711  CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a>  CHP+ Customer Service: 1-800-359-1991/ State Relay 711  Health Insurance Buy-In Program  (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a>  HIBI Customer Service: 1-855-692-6442</p>	<p>Website:  <a href="https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html">https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html</a>  Phone: 1-877-357-3268</p>
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<b>GEORGIA – Medicaid</b>	<b>INDIANA – Medicaid</b>
<p>GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a>  Phone: 678-564-1162, Press 1  GA CHIPRA Website:  <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a>  Phone: (678) 564-1162, Press 2</p>	<p>Healthy Indiana Plan for low-income adults 19-64  Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a>  Phone: 1-877-438-4479  All other Medicaid  Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a>  Phone 1-800-457-4584</p>
<b>IOWA – Medicaid and CHIP (Hawki)</b>	<b>KANSAS – Medicaid</b>
<p>Medicaid Website:  <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a>  Medicaid Phone: 1-800-338-8366  Hawki Website:  <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a>  Hawki Phone: 1-800-257-8563  HIPP Website:  <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a>  HIPP Phone: 1-888-346-9562</p>	<p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a>  Phone: 1-800-792-4884  HIPP Phone: 1-800-967-4660</p>
<b>KENTUCKY – Medicaid</b>	<b>LOUISIANA – Medicaid</b>
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>  Phone: 1-855-459-6328  Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a>  KCHIP Website: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a>  Phone: 1-877-524-4718  Kentucky Medicaid Website:  <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a></p>	<p>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/la hipp">www.ldh.la.gov/la hipp</a>  Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<b>MAINE – Medicaid</b>	<b>MASSACHUSETTS – Medicaid and CHIP</b>
<p>Enrollment Website:  <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a>  Phone: 1-800-442-6003  TTY: Maine relay 711  Private Health Insurance Premium Webpage:  <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>  Phone: 1-800-977-6740  TTY: Maine relay 711</p>	<p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a>  Phone: 1-800-862-4840  TTY: 711  Email: <a href="mailto:masspremiumassistance@accenture.com">masspremiumassistance@accenture.com</a></p>
<b>MINNESOTA – Medicaid</b>	<b>MISSOURI – Medicaid</b>



<p>Website:  <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a>  Phone: 1-800-657-3739</p>	<p>Website:  <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>  Phone: 573-751-2005</p>
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MONTANA - Medicaid	NEBRASKA - Medicaid
Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084 Email: <a href="mailto:HHSIPPProgram@mt.gov">HHSIPPProgram@mt.gov</a>	Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Medicaid Phone: 1-800-992-0900	Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710	Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a> Phone: 919-855-4100	Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a> Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742	Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: <a href="https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx">https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx</a> Phone: 1-800-692-7462 CHIP Website: <a href="http://www.dhs.pa.gov/Services/Assistance/Pages/CHIP-Program.aspx">Children's Health Insurance Program (CHIP) (pa.gov)</a> CHIP Phone: 1-800-986-KIDS (5437)	Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820	Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: <a href="http://www.dhs.texas.gov/HealthInsurancePremiumPaymentProgram">Health Insurance Premium Payment (HIPP) Program</a>   Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: <a href="http://www.dhs.vt.gov/HealthInsurancePremiumPaymentProgram">Health Insurance Premium Payment (HIPP) Program</a>   Department of Vermont Health Access Phone: 1-800-250-8427	Website: <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a> <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a> Medicaid/CHIP Phone: 1-800-432-5924



WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022	Website: <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a> <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

## Women’s Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women’s Health and Cancer Rights Act of 1998 (WHCRA), 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?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

## Newborns’ and Mothers’ Health Protection Act (NMHPA) Notice

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 vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

# Model General Notice of COBRA Continuation Coverage Rights

## **\*\* Continuation Coverage Rights Under COBRA \*\***

### ***Introduction***

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

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

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

### ***What is COBRA continuation coverage?***

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

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

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

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

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



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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

***When is COBRA continuation coverage available?***

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

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

***How is COBRA continuation coverage provided?***

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

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

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

***Disability extension of 18-month period of COBRA continuation coverage***

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children

getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

***Are there other coverage options besides COBRA Continuation Coverage?***

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period<sup>1</sup> 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 or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/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](http://www.HealthCare.gov).

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<sup>1</sup> <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>. These rules are different for people with End Stage Renal Disease (ESRD).



***Keep your Plan informed of address changes***

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

***Plan contact information***

*Attention: Yesica Alejandre*

*Benefits Technician*

*Phone: (562) 602-6029*

*Email: [yalejandre@paramount.k12.ca.us](mailto:yalejandre@paramount.k12.ca.us)*

## APPENDIX

These are additional notices that may be appropriate based upon an employer's circumstances. We included the Surprise Billing Notice to assist with an employer's obligation to post the notice on its website (in those rare circumstances where it may be necessary).

- ☐ HIPAA Privacy Notice of Availability
- ☐ ACA Grandfathered Status Notice
- ☐ Surprise Billing Notice – “Your Rights and Protections Against Surprise Medical Bills”



## HIPAA Notice of Availability of Notice of Privacy Practices

The Paramount Unified School District (Plan) maintains 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 Human Resources.

### Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

#### What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain [out-of-pocket costs](#), like a [copayment](#), [coinsurance](#), or [deductible](#). You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

#### You are protected from balance billing for:

##### *Emergency services*

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

##### *Certain services at an in-network hospital or ambulatory surgical center*

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.**

**When balance billing isn't allowed, you also have the following protections:**

1. You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
2. Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

**If you believe you've been wrongly billed**, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to [learn more about protections from surprise medical bills](#) and for [contact information for the state department of insurance or other similar agency/resource in your state](#) to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

## Notes

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## Notes

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## Notes

