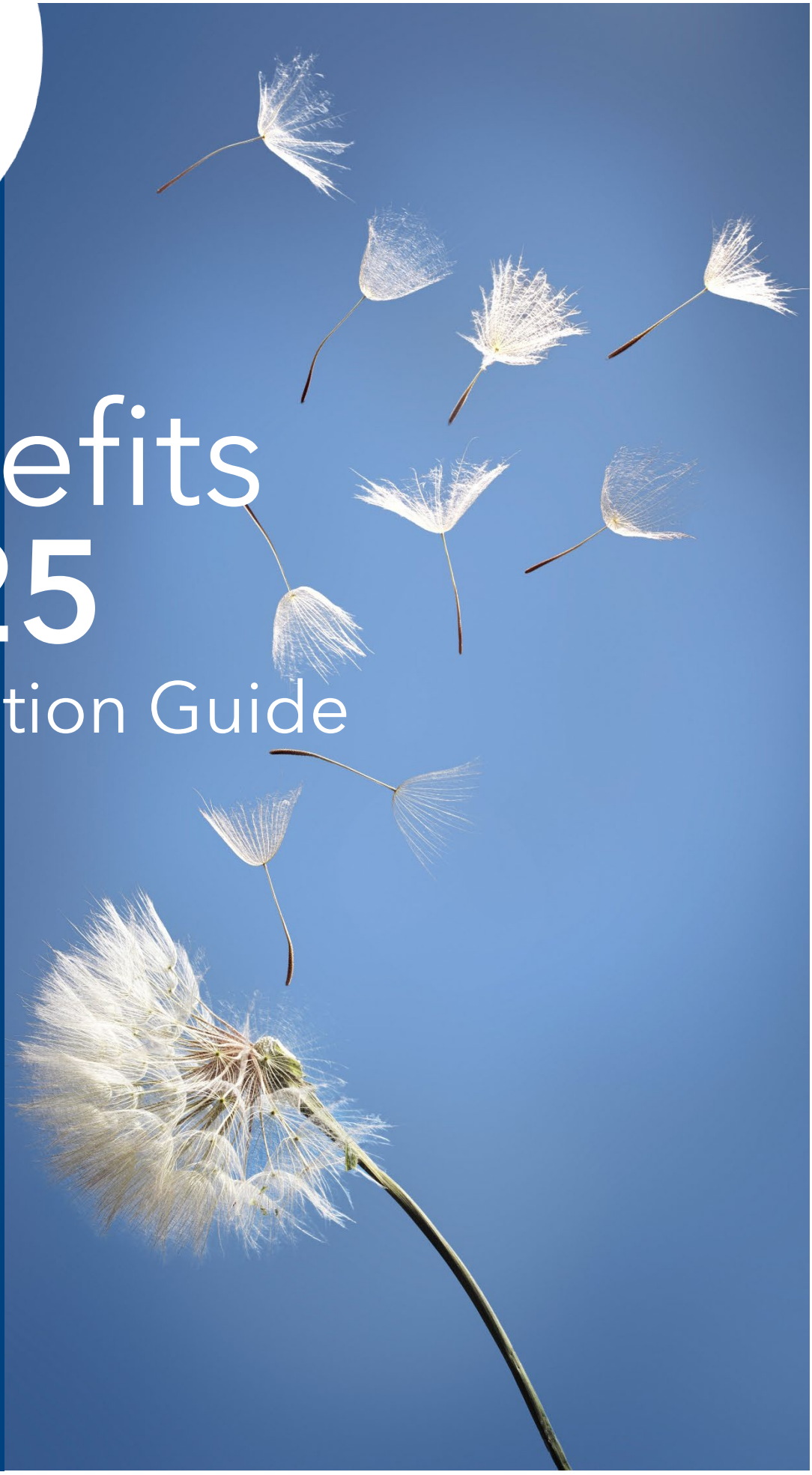
Benefits 2025

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 26 for more details.

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.

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 and use company code SISC to login.

Eligibility & Enrollment

Eligibility & Enrollment

Time to answer some questions…

Who can enroll?

As an eligible early retiree, Paramount Unified School District provides life insurance, health, and dental benefits for you (and your covered dependents at the time of retirement) equal to the cost, which the District pays for active employees until the age of 65.

When does coverage begin?

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.

Medicare Eligibility

Retirees and their Spouses/Registered Domestic Partners that are 65 years of age or older are required to provide proof of Medicare Parts A & B. Medicare information must be sent to the district prior to the first of the month in which they turn 65 (or first of the prior month if their birthday is on the 1st). If proof of Medicare is not provided to the Business Office, a surcharge will be added. Retirees can obtain the surcharge amount from the Business Office.

Retiree Certificated over Age 65

Retired Certificated employees of Paramount Unified School District may be eligible to continue coverage on the Plan.

- If you are eligible for Medicare and assign Parts A & B to Kaiser, you may be eligible for the Kaiser Senior Advantage Plan
- If you are eligible for Medicare and do NOT assign Parts A & B to your Medical Carrier, Kaiser or Blue Cross, you will pay a greatly increased premium
- If you are not eligible for Medicare (some certificated employees do not qualify for Medicare—call your Social Security office) you may be able to continue on the Kaiser or Blue Cross plan. Call the Benefits Office at 562-602-6029 to review your options.

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 or access via www.mybentek.com/paramount

To access Bentek using a mobile device, scan code.

Making changes during Open Enrollment

Open Enrollment is your one chance in a year to review your coverage and make changes to your benefits. The elections made during Open Enrollment will take effect January 1 and be effective through December 31. Open Enrollment occurs each fall, generally in November. Once you've enrolled in benefits, you generally are not allowed to make changes until the next Open Enrollment

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.

Cost Breakdown

The rates below are effective **January 1, 2025 through December 31, 2025.**

Certificated	Medical		Dental	Life
	Kaiser	Blue Cross	Delta Dental	Life
Monthly Premium	$ 769.79	$ 1,018.74	$ 90.20	$ 7.00
District Contribution	$ 541.64	$ 790.59	$ 90.20	$ 7.00
Retiree Only	**$ 228.15**	**$ 228.15**	**$ -**	**$ -**
Monthly Premium	$ 1,539.57	$ 1,812.37	$ 176.35	$ 7.00
District Contribution	$ 1,228.09	$ 1,500.89	$ 176.35	$ 7.00
Retiree +1	**$ 311.48**	**$ 311.48**	**$ -**	**$ -**
Monthly Premium	$ 2,066.88	$ 2,504.32	$ 243.34	$ 7.00
District Contribution	$ 1,692.21	$ 2,129.65	$ 243.34	$ 7.00
Retiree + Family	**$ 374.67**	**$ 374.67**		

Classified & Board	Medical		Dental	Life
	Kaiser	Blue Cross	Delta Dental	Life
Monthly Premium	$ 769.79	$ 1,018.74	$ 90.20	$ 7.00
District Contribution	$ 524.80	$ 773.75	$ 90.20	$ 7.00
Retiree Only	**$ 244.99**	**$ 244.99**	**$ -**	**$ -**
Monthly Premium	$ 1,539.57	$ 1,812.37	$ 176.35	$ 7.00
District Contribution	$ 1,283.39	$ 1,556.19	$ 176.35	$ 7.00
Retiree +1	**$ 256.18**	**$ 256.18**	**$ -**	**$ -**
Monthly Premium	$ 2,066.88	$ 2,504.32	$ 243.34	$ 7.00
District Contribution	$ 1,804.49	$ 2,241.93	$ 243.34	$ 7.00
Retiree + Family	**$ 262.39**	**$ 262.39**		

Management & Confidential	Medical		Dental	Life
	Kaiser	Blue Cross	Delta Dental	Life
Monthly Premium	$ 769.79	$ 1,018.74	$ 90.20	$ 7.00
District Contribution	$ 549.80	$ 798.75	$ 90.20	$ 7.00
Retiree Only	**$ 219.99**	**$ 219.99**	**$ -**	**$ -**
Monthly Premium	$ 1,539.57	$ 1,812.37	$ 176.35	$ 7.00
District Contribution	$ 1,283.39	$ 1,556.19	$ 176.35	$ 7.00
Retiree +1	**$ 256.18**	**$ 256.18**	**$ -**	**$ -**
Monthly Premium	$ 2,066.88	$ 2,504.32	$ 243.34	$ 7.00
District Contribution	$ 1,804.49	$ 2,241.93	$ 243.34	$ 7.00
Retiree + Family	**$ 262.39**	**$ 262.39**		

Monthly Contributions - OverAge 65 (Certificated Retirees Only)

2025 Rates	One Party	Two Party	Three Party/Family
Anthem (Medicare Assigned)	$ 1,116.40	$ 2,232.78	$ 2,927.74
Kaiser (Medicare Assigned	$ 332.99	$ 665.97	$ 1,304.90
Delta Dental	$ 111.52	$ 204.90	$ 226.62
Anthem (Medicare Not-Assigned)	$ 2,570.97		
Kaiser (Medicare Not-Assigned)	$ 1,640.54		


Medical

Medical

Which plan type is right for you?

HMO	PPO
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.	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.
Advantages	
Lower out-of-pocket costs. Care coordinated by PCP.	Broader choice of providers. No referrals required for specialists.
Out-of-pocket costs	
Both copays and coinsurance are generally a lower out-of-pocket expense than a PPO plan.	You'll be responsible for copays and coinsurance, but your deductible will be lower than the HDHP plan.
Ideal if...	
... you prefer a lower payroll deduction and are comfortable with a PCP directing your care.	... 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 Kaiser HMO: 1.Go to 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	**Finding a provider for Anthem Blue Cross:** 1.Go to 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
Note:	
Out-of-network services without proper PCP referral will not be covered.	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 or www.Navitus.com
Mail order for Anthem Blue Cross PPO Participants

WHY PAY MORE?

There are a few ways you can save money when using the

Costco Pharmacy Retail Program

Want to save money on your prescription medications?
Take Advantage of Free Generic Medications at Costco:

- Take your prescription for a generic medication to a Costco Pharmacy
- Present the pharmacists with your insurance card
- 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.

Plan Highlights

KAISER PERMANENTE®

Kaiser Permanente HMO	In-Network Only
Annual Calendar Year Deductible	
Individual	None
Family	None
Maximum Calendar Year Out-of-pocket (1)	
Individual	$1,500
Family	$3,000
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP)	$10 per Visit
Specialist	$10 per Visit
Preventive Care Exam	No Charge
Well-baby Care	No Charge
Diagnostic X-ray and Lab	No Charge
Complex Diagnostics (MRI/CT Scan)	No Charge
Therapy, including Physical, Occupational and Speech	$10 per Visit
Hospital Services	
Inpatient	No Charge
Outpatient Surgery	$10 per procedure
Emergency Room	$35 per Visit
Urgent Care	$10 per Visit
Maternity Care	
Physician Services (prenatal or postnatal)	No Charge
Hospital Services	No Charge
Mental Health & Substance Abuse	
Inpatient	No Charge
Outpatient	$10 per individual Visit/$5 per group Visit
Retail Prescription Drugs (1 to 100 days' supply)	
Contraceptive Drugs & Devices	No Charge
Tier 1 – Generic	$5 Copay
Tier 2 – Preferred Brand	$10 Copay
Tier 3 – Non-Preferred Brand	$10 Copay
Tier 4 – Specialty	$10 Copay
Eye Exam	No Charge
Glasses Every 24 months	$125 Allowance

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) This runs from January 1st until December 31st. This will reset on January 1st and any expenses incurred previously will not count towards your deductible or out of pocket maximum. This could lead to additional expenses.

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

KAISER PERMANENTE®

231395 ASCIP- PARAMOUNT UNIFIED SCHOOL DISTRICT

Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/25—12/31/25)

Plan Out-of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount: For any one Member	$1,000 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	No charge
Most Physician Specialist Visits	No charge
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	No charge
Physical, occupational, and speech therapy	No charge
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	No charge
Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Services	**You Pay**
Emergency department visits	No charge
Ambulance and Transportation Services	**You Pay**
Ambulance Services	No charge
Other transportation Services when provided by our designated transportation provider as described in this *EOC*	No charge for up to 24 one-way trips (50 miles per trip) per calendar year
Prescription Drug Coverage	**You Pay**
This plan covers Medicare Part D prescription drugs in accord with our Part D formulary.	
Initial coverage stage—until you have spent $2,000 in 2025. (If you spend $2,000, you move on to the catastrophic coverage stage)	$5 for up to a 100-day supply
Catastrophic coverage stage	No charge
Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	No charge

continues

Principal Benefits for
Kaiser Permanente Senior Advantage (HMO) with Part D (01/01/25–12/31/25)

continued

Mental Health Services	You Pay
Group outpatient mental health treatment	No charge
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	No charge
Group outpatient substance use disorder treatment	No charge
Home Health Services	**You Pay**
Home health care (part-time, intermittent)	No charge
Other	**You Pay**
Eyeglasses or contact lenses every 24 months	Amount in excess of $150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	No charge
Meals delivered to your home immediately following discharge from a network hospital or Skilled Nursing Facility	No charge up to three meals per day in a consecutive four-week period, once per calendar year
Over-the-Counter (OTC) Health and Wellness products obtained through our OTC catalog	No charge for a quarterly benefit limit of $70
Fitness benefit – One Pass™ (includes access to in-network gyms and one home fitness kit per calendar year)	No charge

***Summary of Benefits* booklet**

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For additional information, please refer to the *Summary of Benefits* booklet enclosed; for a complete explanation, refer to the *EOC*.

Plan Highlights

Anthem Blue Cross PPO	In-Network Only	Out-of-Network Only
Annual Calendar Year Deductible		
Individual	None	None
Family	None	None
Maximum Calendar Year Out-of-Pocket (1) (2)		
Individual	$1,000	Not Applicable
Family	$3,000	Not Applicable
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Physician (PCP)	$0 Copay per Visit 1-3, then $20 Copay per Visit 4+	See footnote 3
Specialist	$20 per Visit	See footnote 3
Preventive Care Exam	No Charge	Not Covered
Prenatal and Post-natal Care	$0 Copay per Visit 1-3, then $20 Copay per Visit 4+	Not Covered
Online Visits (LiveHealth Online) Includes Mental/Behavioral Health and Substance Abuse	$20 Copay	Not Covered
Diagnostic X-ray and Lab	No Charge	Not Covered
Complex Diagnostics (MRI/CT Scan)	No Charge	See footnote 3 (benefit limited to $800 per procedure)
Therapy, including Physical, Occupational and Speech	No Charge	Not Covered
Hospital Services		
Inpatient	No Charge	All billed amounts exceeding $600 a day
Outpatient Surgery	No Charge	All billed amounts exceeding $350 a day
Emergency Room	$100 per Visit (waived if admitted)	$100 per Visit (waived if admitted)
Ambulance	$100 Copay (No additional charge if true emergency)	$100 Copay (No additional charge if true emergency)
Urgent Care	$20 per Visit	See footnote 3
Maternity Care		
Physician Services (prenatal or postnatal)	$20 per Visit	See footnote 3
Hospital Services	No Charge	See footnote 3
Mental Health & Substance Abuse		
Inpatient	No Charge	All billed amounts exceeding $600 per day
Outpatient	No Charge	See footnote 3
Retail Prescription Drugs (30-day supply)		
Rx Brand Deductible	No Deductible	Not Applicable
Rx Out-of-Pocket Maximum	$2,500 Individual/$3,500 Family	Not Covered
Contraceptive Drugs & Devices	No Charge	No Charge
Tier 1 – Generic	$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 – Preferred Brand	$20 Copay	
Tier 3 – Non-Preferred Brand	$35 Copay	
Tier 4 – Specialty Drugs	Not Covered	Not Covered
Mail Order Prescription Drugs (90-day supply) Navitus mail order through Costco		
Contraceptive Drugs & Devices	No Charge	No Charge
Tier 1 – Generic	$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 - Preferred Brand	$45 Copay	
Tier 3 – Non-Preferred Brand	$90 Copay	
Tier 4 – Specialty Drugs	Not Covered	Not Covered
Eye Exam through MES Vision – Every 12 months	$10 Copay	$40 Allowance
Glasses	20% Discount	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. This runs from January 1st until December 31st. This will reset on January 1st and any expenses incurred previously will not count towards your deductible or out of pocket maximum. This could lead to additional expenses.

3. The plan pays 100% of the fee schedule. The member is responsible for all amounts exceeding the fee schedule.

P3 Paramount Personal Physician

Concierge-style, high caliber care at the work place

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 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.

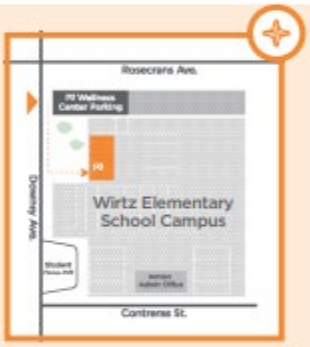
A+ CARE

The P³ program was created to deliver concierge style, high caliber care at the work place. 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. Benefits include:

- $0 out of pocket for services provided at the P³ 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

- Total Women Care (No OB)
- Sports physicals
- Annual physicals
- Blood draws
- Chronic condition management
- Acute Illnesses
- Minor injuries
- Vaccinations
- Skin procedures
- Virtual visits



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

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. As a precaution, all visitors to the P³ Wellness Center will be required to wear a face covering. 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 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
Individual	$2,500 per person	
Family	100%	100%
Annual Maximum	100%	100%
Preventive	70%	50%
Basic Services	Not Covered	Not Covered
Major Services	100%	100%
Orthodontia Services	None	None
Lifetime Maximum	$2,500 per person	

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.

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		
Additional Pairs of Glasses	35% off retail price	
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.

Create a member account at 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

Life & Disability

Life & Disability

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, outlined below are provided by Reliance Standard:

- Basic Life Insurance of $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.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

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

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	Mental Health Support: • Marital, relationship or family problems. • Bereavement or grief counseling. • Substance abuse and recovery. Community Support: • Childcare and eldercare. • Legal services and Identity theft. • Financial support. • Educational materials.
Who can utilize	All employees, dependents of employees, and members of your household

Get in touch:

By phone: 800.999.7222.

Online: www.anthemeap.com

Website password: SISC.

Directory, & Required Notices

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 • Trish Rodriguez, Risk Management/Benefits • Amelia Nuñez, Executive Assistant	 562.602.6029 562.602.6027 562.602.6025	 YAlejandre@paramount.k12.ca.us PRodriguez@paramount.k12.ca.us amnunez@paramount.k12.ca.us
Medical Coverage		
Kaiser Permanente HMO Anthem Blue Cross – PPO • BlueCard (Out of State/World Wide) • P3 (Paramount Personal Physician for Anthem Blue Cross) • Navitus Pharmacy Services (Anthem Blue Cross members) • Medical Eye Services (Anthem Blue Cross Vision Plan) • American Specialty Health • Anthem Employee Assistance Program	 800.464.4000 800.825.5541 800.810.2583 562.408.1033 866.333.2757 800.877.6372 800.972.4226 800.999.7222	 www.kp.org www.anthem.com/ca/sisc/ www.bcbs.com/bluecardworldwide **Email:** Paramountp3@stjoe.org www.navitus.com www.mesvision.com www.ashcompanies.com anthemEAP.com
Dental Coverage		
Delta Dental PPO	866.499.3001	www.deltadentalins.com
Vision Coverage		
EyeMed • PPO	866.804.0982	www.eyemed.com
Credit Unions		
SchoolsFirst Federal Credit Union	800.462.8328	www.schoolsfirstfcu.org
First Financial Credit Union	800.537.8491	www.ffcu.org
Mid Cities Credit Union	310.638.5147	www.midcitiescu.org
Unions		
CSEA-California School Employees Association	800.988.6949	www.csea.com
CTA-California Teachers Association	562.942.7979	www.cta.org
Retirement Resources		
State Teachers Retirement System (STRS) California Public Employees' Retirement System (CalPERS) Social Security Administration Medicare	800.228.5453 888.225.7377 800.772.1213 800.633.4227	www.calstrs.com www.calpers.ca.gov www.ssa.gov www.medicare.gov

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.

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.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan 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
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Paramount Unified School District
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

Effective Date

This Notice as revised is effective January 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:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) 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.**

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

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

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

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

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremiumassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA - Medicaid	NEBRASKA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 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: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program| Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

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

To see if any other states have added a premium assistance program since 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
1-866-444-EBSA (3272)

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

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."

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

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

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**. (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**.

[1] 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

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 balanced 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.

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Prepared by: Marsh & McLennan Insurance Agency LLC
www.MarshMMA.com | CA Insurance Lic: 0H18131