2022

Benefits Information Guide – Active

PARAMOUNT UNIFIED SCHOOL DISTRICT

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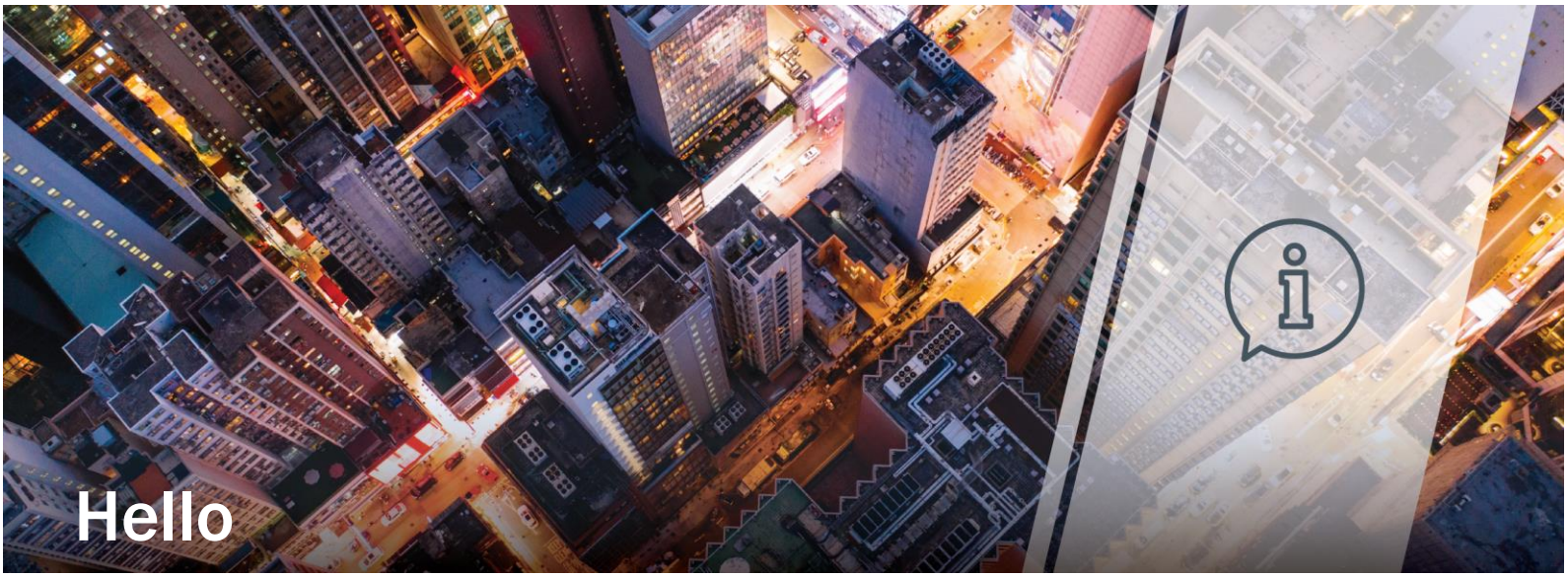


Hello

Welcome to your 2022 Benefits Information Guide.

The Business Services Department is pleased to provide you with the 2022 Health and Welfare Employee Benefits Guide. This booklet is a comprehensive tool on the benefits plans available to you and will assist you during the annual open enrollment period. Open enrollment period is the time of year when employees are encouraged to take the opportunity to re-evaluate current and future benefits needs. Understanding your benefits options is important; therefore, we encourage you to review this booklet carefully.

You may also visit the Paramount USD website; the website provides detailed information on the benefits plans available to you. This will assist you during the annual open enrollment period and throughout the year.

Sincerely,

Patricia Tu and Scott Law
Interim Assistant Superintendents-Business Services

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 2 months, Federal law gives you more choices about your prescription drug coverage. Please see page (21) for more details.

Eligibility & Enrollment

Who Can Enroll?

All Benefits-Eligible employees are required to be covered under the District's Health & Welfare.

Dependent Eligibility:

Benefits-Eligible employees can enroll eligible dependents. Eligible dependents Include:

- Legal Spouse - Official Marriage Certificate is required
- California Registered Domestic Partner - Valid Certified copy of the Declaration of Domestic Partnership filed with the Secretary of State is required
- Your natural children or stepchildren - Official Birth Certificate is required. Dependent Children may continue coverage until age 26
- Adopted children or court-appointed guardianship of children - Official court approved documentation is required

When to Enroll?

You are eligible to enroll in benefits and make changes to your benefits only:

- When you're initially eligible
- During Annual Open Enrollment
- If you experience a qualifying event change

How Do I Enroll?

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 the Employee Benefits Center:

1. Log on to 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.

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on IRS qualified change in status events for more information.

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. Once you've enrolled in benefits, you generally are not allowed to make changes until the next Open Enrollment.

Important Note:

All Active, Benefits-Eligible Employees Must:

- Confirm elections and beneficiaries
- Authorize benefits deductions
- Re-enroll for Flexible Spending Accounts (FSA's)

Making Changes 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.

Opt-Out Option

You are eligible to opt-out of the District's Health & Welfare only if you and your spouse are both Benefits-Eligible employees of Paramount Unified School District. You must be a covered dependent under your spouse's coverage. If you are eligible to opt-out of your medical coverage, you must complete an opt-out form during Open Enrollment. Opt-Out forms are available in the Benefits Office.

Cost Breakdown

The rates below are effective January 1, 2022 through December 31, 2022.

Total Insurance Premium	Tenthly Rates
	10 pay periods per year
Kaiser Permanente HMO	Total Premium
One Party	$760.97
Two Party	$1,521.94
Three Party/ Family	$2,153.54
Anthem Blue Cross PPO	
One Party	$949.21
Two Party	$1,798.42
Three Party/ Family	$2,484.80
Delta Dental PPO	
One Party	$157.66
Two Party	$157.66
Three Party/ Family	$157.66
Life Insurance	
One Party	$7.60
Two Party	$7.60
Three Party/ Family	$7.60

Employee Tenthly Contributions

	One Party	Two Party	Three Party/ Family
Current Employee Contributions (2020)			
TAP Employees	$273.78	$373.78	$449.60
CSEA and Board Members	$293.99	$307.41	$314.87
Management, Supervisory and Confidential	$263.99	$307.41	$314.87
Employee Contributions (2021)*			
TAP Employees	$273.78	$373.78	$449.60
CSEA and Board Members	$293.99	$307.41	$314.87
Management, Supervisory and Confidential	$263.99	$307.41	$314.87

Medical

What Are My Options?

Use the chart below to help compare medical plan options and determine which would be the best for you and your family.

	HMO	PPO
	Kaiser Permanente	**Anthem Blue Cross**
Required to select and use a Primary Care Physician (PCP)	**Yes**	No
Seeing a Specialist	PCP referral required in most cases	No referral required
Deductible Required	No	No
Finding a Provider	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	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: I. Searching for: **Medical** II. State: **California** III. Type of Plan: **Medical (Employer-Sponsored)** ➢ PPO Network: **Blue Cross PPO (Prudent Buyer) – Large Group** 5. Select the parameters that you'd like to search for and click **Continue**
Claims Process	• Handled by Kaiser	• Handled by providers for in-network services • Member submits claims to Anthem for out-of-network services
Other Important Tips	• This plan requires that you see a doctor in Kaiser to receive coverage • Out-of-Network services without proper PCP referral will not be covered • Emergencies covered worldwide	• You may choose in or out of network care, however in-network care provides you a higher level of benefit • Out-of-network providers will balance bill the member for amounts not covered by Anthem • Emergencies covered worldwide

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.

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.

Plan Highlights

Anthem Blue Cross PPO	In-Network Only	Out-of-Network Only
Annual Calendar Year Deductible		
Individual / Family	None / None	None / None
Maximum Calendar Year Out-of-Pocket (1) (2)		
Individual / Family	$1,000 / $3,000	No limit person or Family
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
Online Visits (LiveHealth Online) Includes Mental/Behavioral Health and Substance Abuse	$10 Copay	See footnote 3
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)	Copay waived for first 3 visit, then $20 copay	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.

Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

- The Kaiser and Anthem plans (provided through Navitus) cover generic formulary, brand-name formulary, non-formulary brand, and specialty drugs
- Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts
- A brand-name medication is protected by a patent and can only be produced by one specified manufacturer
- Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list
- 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 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 pharmacists 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.

P3 Paramount Personal Physician

Concierge-style, high caliber care at the work place

COMPLIMENTARY MEDICAL SERVICES

- Total Women Care (No OB)
- Sports physicals
- Annual physicals
- Lifestyle measurements
- Chronic condition management
- Acute illnesses
- Minor injuries
- Blood draws
- Electronic prescribing
- Vaccinations
- Skin procedures

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, will be screened for COVID-19 symptoms, and will have their temperature taken upon arrival. 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.

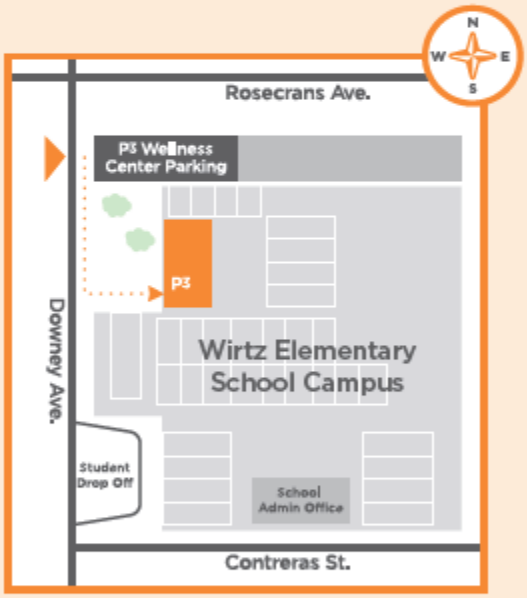
We look forward to hearing from you and customizing your appointment and treatment plan around your individual needs.

SERVICES	IN OFFICE	VIRTUAL VISIT (ZOOM OR TELEPHONE)
Preventive Services *Physicals, vaccines, InBody analysis*	X	
Nurse Visits *Lab draws, injections, etc.*	X	
Medication Monitoring	X	X
Skin Procedures	X	
Preoperative Clearance	X	
Sick Visits		X

MEET YOUR PROVIDER

Judy K. Lee Vogt, MD

Dr. Lee Vogt is a board certified family physician with more than 20 years' experience practicing medicine. She treats her patients with dignity, compassion and respect, emphasizing lifestyle modifications and preventative measures to help them achieve optimum health and wellness. As a physician who speaks English and Spanish, Dr. Lee Vogt 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

Hours of Operation

Mon. — 9 a.m. - 5:30 p.m.
Tues. - Fri. — 7 a.m. - 4 p.m.*
**Limited services on Tuesday & Friday*

The P3 Wellness Center is available to Paramount Unified School District 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.

Vision

Medical Eye Services Vision Carrier for Anthem Blue Cross PPO Participants

Your employer understands the importance of good visual health and the need for regular eye examinations. The Vision Plan, administered by Medical Eye Services (MESVision), is designed to provide you with access to qualified eye care professionals and coverage for a comprehensive vision examination.

Summary of Vision Benefits

- Co-Pay: $10
- Comprehensive Vision Exam: One every 12 months

If you have any questions about your vision benefits, please contact Medical Eye Services at:

PO Box 25209
Santa Ana, CA 92799
Phone: 800.877.6372
Website: www.mesvision.com/

MES Vision®

TIP

Five Tips for Superior Vision

Don't take your eyes for granted! The following pointers can help you keep your vision strong:

- **Eat lots of leafy greens and dark berries**
- **Get regular eye exams**
- **Give your eyes a rest from staring into the computer screen**
- **Wear sunglasses to protect your eyes from bright light**
- **Wear safety eyewear whenever necessary**

Dental Plan

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by Delta Dental. 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.

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 -Oral exams, routine cleanings (2 cleanings per calendar year, 3rd cleaning allowed during pregnancy), x-rays, fluoride treatment, space maintainers, specialist consultations	100%	100%
Basic Services -Fillings, root canals, periodontics (gum treatment), tissue removal (biopsy), oral surgery (extractions), sealants	100%	100%
Major Services -Bridges, partial dentures, full dentures, implants	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.

TIP

Choose Your Dentist

When using a Dental PPO plan, you can receive services from dental providers both in and out of your insurance network. However, you'll receive better coverage when you use an in-network dentist. To determine whether your dentist is in or out of your insurance network, go to www.DeltaDentalins.com and search the provider network, or call 866.499.3001

DELTA DENTAL®

Life and AD&D

Protect Your Loved Ones

In the event of your death, 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.

Your Coverage

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.

TIP

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**

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

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 for purchase on a payroll deduction basis through Reliance Standard.

- **For employees:** Increments of $10,000 (not to exceed $500,000)
- **For your spouse/ state registered domestic partner:** Increments of $10,000 (not to exceed $500,000)
- **For your child(ren):** Age 14 days to 6 months $1,000
- **For your child(ren):** Age 6 months to age 20; increments of $2,500, $5,000, $7,500, or $10,000

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

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

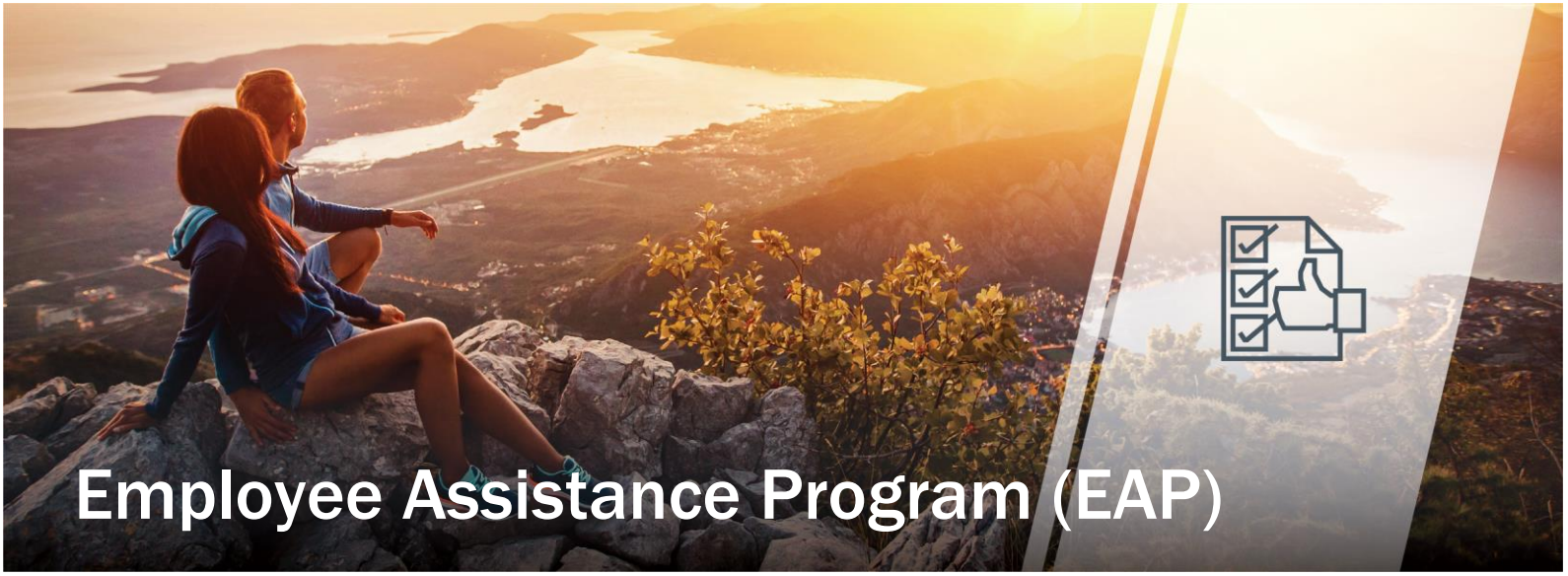
Dependent Child Coverage

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

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.

Example of Cost	Election	Tenthly Cost
Basic Dependent Life	$5,000 each	$1.90
Employee age 30	$100,000	$15.00
Spouse age 36	$30,000	$5.70
Children (all)	$10,000 each	$2.00
Total Tenthly Deduction:		$24.60

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP



Employee Assistance Program (EAP)

Employee Assistance Program (EAP)

Anthem understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Who Can Utilize	All employees, your dependents, and members of your household
Number of sessions	6 One-on-one counseling by phone, in-person and Online per year per member per issue
Topics May Include	• Workplace safety • Child and elder care resources • Tobacco cessation • Grief and loss • Family health • Home improvement • Addiction and recovery • Dealing with identity theft • Free, confidential help 24 hours a day, 7 days a week
Accessing Your EAP	• By Phone: 800.999.7222 • Log on to: AnthemEAP.com • Access Code: SISC

Anthem

Flexible Spending Accounts (FSA's)

A flexible spending account lets you use pre-tax dollars to cover eligible health care and dependent care expenses. The accounts are administered by TASC. You may participate in two accounts, the Healthcare and the Dependent Care Reimbursement Accounts.

Rules You Need to Know:

- Although the FSA plan year runs from January 1, 2022 through December 31, 2022, the plan allows a grace period allowing you to incur expenses 2 ½ months after the plan year ends
- If you are currently enrolled in a Flex Spending Account of any kind, you must fill out a new enrollment form every year to continue

FSA Type	Detail
Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2022 is $2,750.
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) child care expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2022 is $5,000.

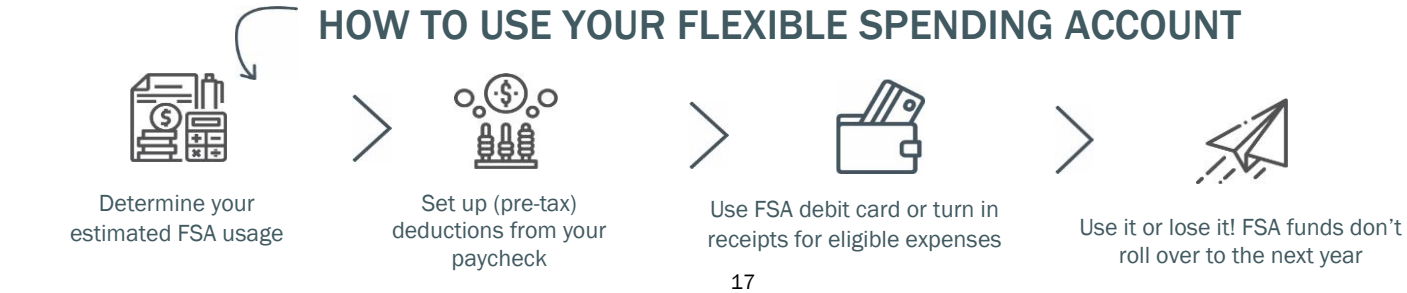
What Are the Benefits?

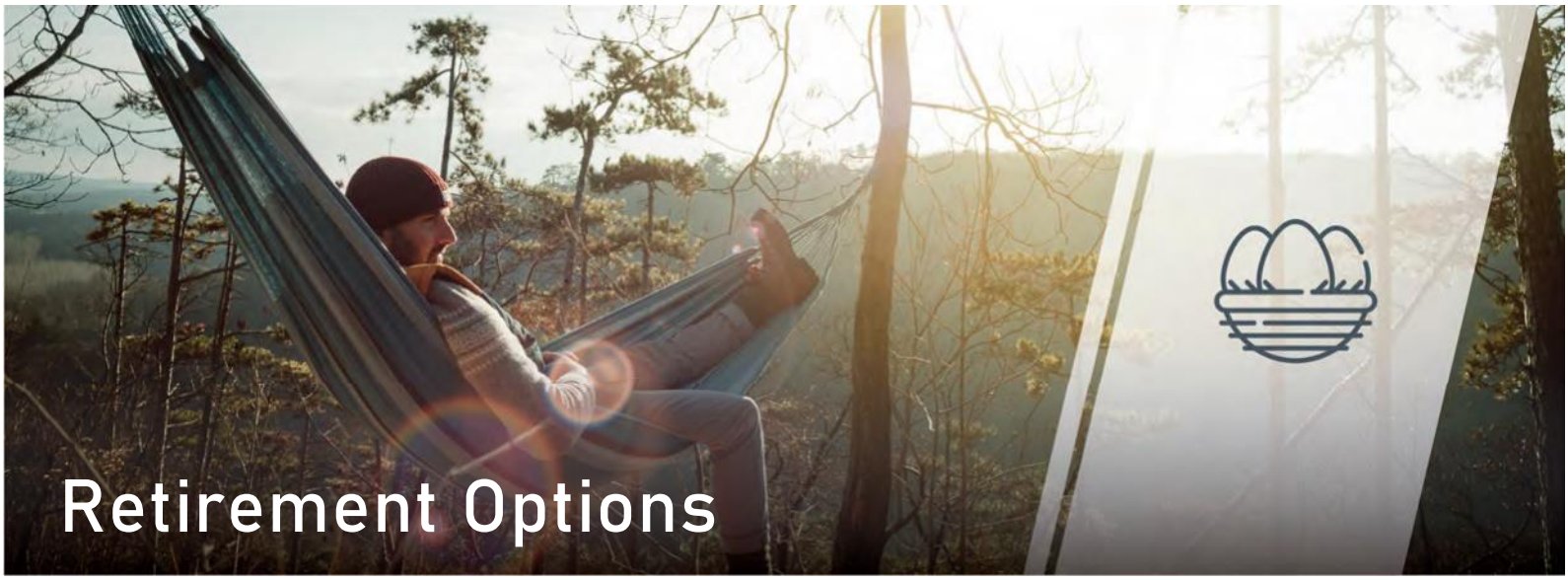
- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy

How Do I Use It?

- You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status and more. Visit www.tasconline.com to access TASC's online portal
- You will receive a debit card for your Healthcare FSA, however receipt backup may still be needed

For more details about using an FSA, visit www.tasconline.com or contact Business Services at 562.602.6027.





Retirement Options

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
- 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. For login or password assistance please contact SchoolsFirst FCU at 800-462-8328 or 714-258-4000

Contribution Changes: Check with Business Services for frequency and process for changing your contributions. You may also stop your contribution entirely at any time. Requests to change or stop your contributions must be made through the provider website or in writing to Business Services.

Employer Contributions: Check with Business Services for current status of any employer contributions to the plan.

Rollover Contributions: If you have an outside qualified retirement plan, you may be able to transfer that account into your new plan. Please contact SchoolsFirst FCU or Business Services for additional information.

Termination of Employment: Upon termination of employment from our organization, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another plan or IRA. You may also request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties which may apply to any payment other than a rollover.

Benefits Information On the Go!

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 ingagedbenefits.com/login and use company code **PUSD** to login.

Kaiser Permanente – On the Go!

The KP mobile app gives you a suite of tools to use on the go! Use this application with your Kaiser Permanente user ID and password to:

- See your health history at your fingertips
- Refill prescriptions for yourself or another member
- Schedule, view, and cancel appointments
- Access your message center to email your doctor or another KP department
- Find KP locations and facilities near you

Search for Kaiser's mobile app in the App Store or Google Play to get started!

Anthem – On the Go!

With Anthem's mobile app, you can:

- Find a doctor, hospital or urgent care facility
- Log in to view your personal benefits information
- Fax or email your Mobile ID card from your smartphone or device directly to your doctor
- Contact Anthem Customer Support directly from the app

Search for Anthem's mobile app in the App Store or Google Play to get started!

Delta Dental – On the Go!

Want more information about your dental plan? Take advantage of Delta Dental's mobile resource to:

- Check your eligibility
- Look up coverage details
- Check claims
- Find a network dentist
- Improve your oral wellness
- And more!

Search for Delta Dental's mobile app in the App Store or Google Play to get started!

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	YAlejandre@paramount.k12.ca.us
• Trish Rodriguez, Risk Management/Benefits	562.602.6027	PRodriguez@paramount.k12.ca.us
• Amelia Nuñez, Executive Assistant	562.602.6025	amnunez@paramount.k12.ca.us
Medical Coverage		
Kaiser Permanente HMO	800.464.4000	www.kp.org
Anthem Blue Cross – PPO	800.825.5541	www.anthem.com/ca/sisc/
• BlueCard (Out of State/World Wide)	800.810.2583	www.bcbs.com/bluecardworldwide
• P3 (Paramount Personal Physician for Anthem Blue Cross members)	562.408.1033	**Email:** Paramountp3@stjoe.org
• Navitus Pharmacy Services (Anthem Blue Cross members)	866.333.2757	www.navitus.com
• Medical Eye Services (Anthem Blue Cross Vision Plan)	800.877.6372	www.mesvision.com
• American Specialty Health	800.972.4226	www.ashcompanies.com
• Anthem Employee Assistance Program	800.999.7222	anthemEAP.com
Dental Coverage		
Delta Dental • PPO	866.499.3001	www.deltadentalins.com
Life, AD&D and Disability		
Reliance Standard • Life, AD&D • Voluntary Life, AD&D	800.351.7500	www.reliancestandard.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
Supplemental Benefits (Voluntary Plans)		
AFLAC • Accident, Critical Illness, Cancer, Hospital Confinement	800.992.3522	www.aflac.com
Colonial Life • Accident, Critical Illness, Cancer, Hospital Confinement	800.325.4368	www.coloniallife.com
American Fidelity • Income Protection Only	800.365.9180	www.americanfidelity.com
National Teachers Association (NTA) • Accident, Cancer, Heart, Disability, Life	972.532.2100	www.ntalife.com
The Standard (Available to CTA members only) • Disability and Life	800.522.0406	www.standard.com
Flexible Spending Accounts		
TASC FSA Vendor	800.422.4661	www.tasconline.com
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)	800.228.5453	www.calstrs.com
California Public Employees' Retirement System (CalPERS)	888.225.7377	www.calpers.ca.gov

Medicare Part D notice

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, 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 15 to December 7. 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 prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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

Your medical benefits brochure contains a description of your current prescription drug benefits.

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 your employer and don't join a Medicare prescription 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 your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription 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).**

Legal Information Regarding Your Plans

REQUIRED NOTICES

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) 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.

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage [(1)]
- Acquisition of a new spouse or dependent through marriage [(1)], adoption [(1)], placement for adoption [(1)] or birth [(1)]
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) [(1)]
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

- You do not need prior authorization from your insurance provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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.

(1) Indicates that this event is also a qualified "Change in Status"
(2) Indicates this event is also a HIPAA Special Enrollment Right
(3) Indicates that this event is also a COBRA Qualifying Event

CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

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 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:

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

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.

How is COBRA continuation coverage provided? (Continued)

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still 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/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

Plan contact information

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

For More Information

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Human Resources Representative.

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

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

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [1]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [1]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [2], and if at least 50 employees are employed by the employer within 75 miles.

[1] The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"

[2] Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627 www.wagehour.dol.gov

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

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

This notice is EFFECTIVE: January 1, 2022

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- **Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.**
- **Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.**
- **Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.**
- **Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.**
- **Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.**

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- **Maintain the privacy and security of your health information.**
- **Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**
- **Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.**
- **Abide by the terms of this notice.**
- **Notify you if we are unable to agree to a requested restriction, amendment or other request.**
- **Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).**
- **Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.**

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

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

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

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

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 January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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)	**MONTANA – 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: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – 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: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

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

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