FENTON

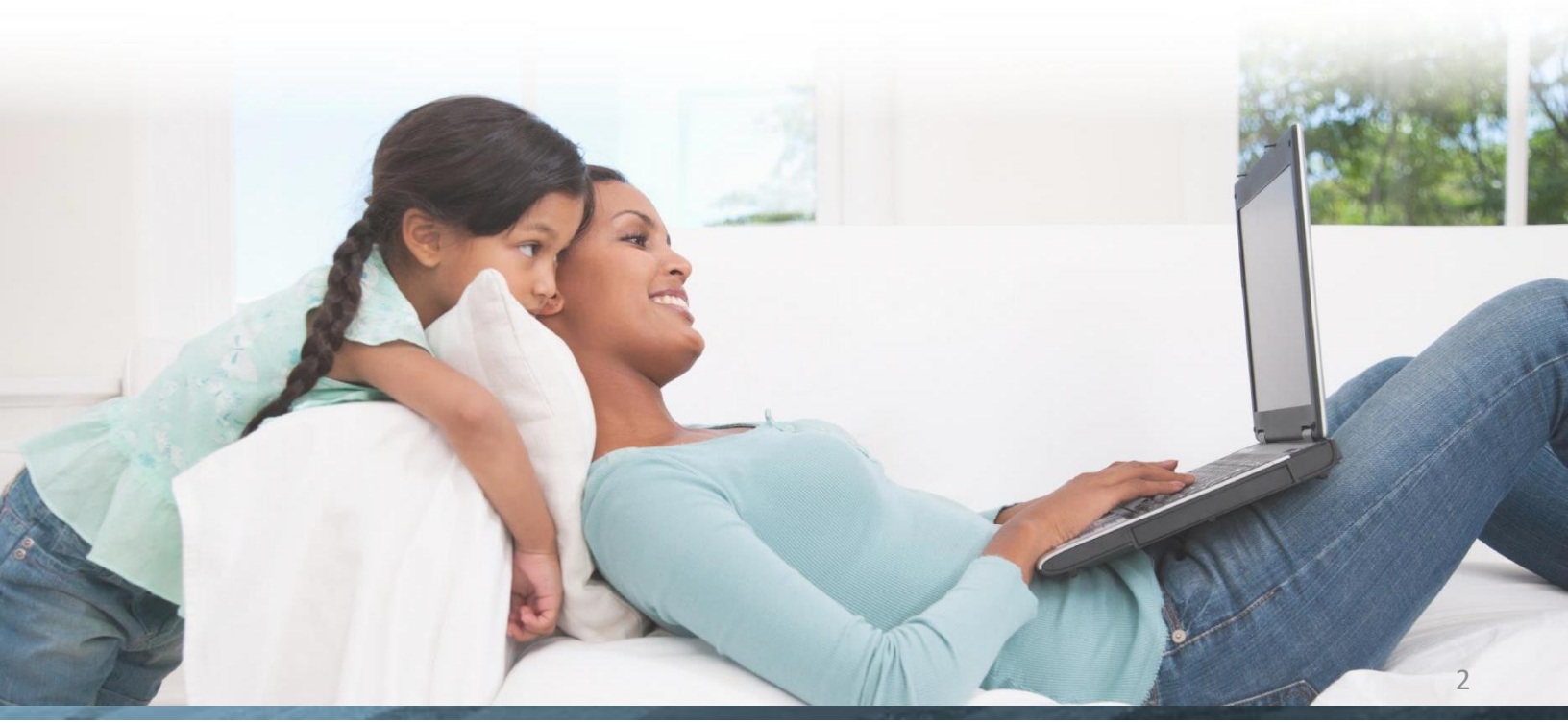
CLIMBING NEW HEIGHTS TOGETHER

EMPLOYEE BENEFITS GUIDE

July 1, 2022 – June 30, 2023

BENEFITS AT A GLANCE

BENEFITS	COVERAGE OPTIONS
Medical	• Health Net Elect Open Access POS 20/250 • Kaiser Traditional HMO 20/250
Dental	• ASCIP Delta Dental PPO
Vision	• ASCIP VSP Signature Vision
Life & Disability	• Unum Basic Life/AD&D • Voluntary Unum Life/AD&D • Unum Short Term Disability • Unum Long Term Disability
Additional Benefits	• LifeWorks Employee Assistance Program (EAP) • Voluntary Unum Accident • Voluntary Unum Critical Illness • Voluntary Unum Hospital Indemnity • Voluntary Unum Whole Life • Unum Long Term Care • Voluntary ASPCA Pet Insurance • Voluntary LegalShield and IDShield Legal and ID Theft Services



YOUR EMPLOYEE SUPPORT CENTER (ESC)

FLEXIBLE SOLUTIONS FOR *your* BENEFITS NEEDS

Gallagher Employee Support Center provides a dedicated team of specialized representatives ready to assist employees and dependents. Your Employee Support Center (ESC) is available to you via a toll-free hotline Monday through Friday, 8a.m. to 4p.m. (PST) or via email inquiry.

The ESC team can support you as you utilize your benefits by providing education and issue advocacy when necessary. The licensed representatives will work with both providers and the insurance companies on your behalf while protecting the privacy of your healthcare information. You can also contact the ESC if you have questions or need assistance selecting the right health insurance plan for you and your family.

HOW CAN WE HELP?

Don't know where to turn?
We guide the way.
Find providers, arrange treatments and tests, coordinate pre-authorizations and referrals.

Confused by health insurance?
We bring clarity.
Full plan education, plan benefits comparison, transition of care for new members, review of claims, payments and outstanding invoices.

Want to save on healthcare?
We help find solutions.
Investigate coverage denials, negotiate payment arrangements with providers, provide information for non-covered services.

Look for this icon throughout this guide for helpful tips from your Employee Support Center!

RELIABLE, CONFIDENTIAL ANSWERS.

Our personal, one-on-one, bilingual and highly experienced team members will explain every step of the way as they confidentially navigate your issue until it has been resolved.

YOUR PERSONAL ADVOCATE

Mon-Fri | 8am-4pm (PST)
Toll Free: **855.670.2222**
Local: **818.539.8804**
LosAngeles.ESC@ajg.com

Due to privacy regulations, our representatives will be required to obtain personal identifying information such as full name, contact information, address, date of birth and in some cases SSN or Member ID #. **Please have this information ready.**

Some inquiries may require for you to provide HIPAA release in order for our advocates to work efficiently in resolving your issue with your provider or carrier.

FENTON INSURANCE OPT-OUT

Eligible full-time employees who have the minimum essential coverage, as required by law, through a spouse or parent, and who do not wish to be covered by any of the plans offered by Fenton Charter Public Schools, may decline coverage and receive a $4,500 stipend (annually) if hired prior to 2012 or a $2,500 stipend (annually) if hired after 2012 in lieu of health benefits. This amount is considered taxable income. It is paid in installments through the employee's regular payroll checks and will be pro-rated based on the employee's hire date.

Opting out of health coverage is optional and not permanent. Employees may choose to enroll in coverage through Fenton Charter Public Schools during the annual Open Enrollment period or due to a Qualifying Family Status Change.

Special Enrollments
You must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing towards the other coverage). If you do not do so, you will not be able to enroll until your employer's next open enrollment period.

Please be aware that under the provisions of the Affordable Care Act (ACA), individuals who do not have minimum essential coverage for themselves and their dependents either through a group sponsored plan, the individual market or through the exchange beginning in January 2014 may have to pay a tax penalty. For more information about the ACA please visit: HealthCare.gov or The Tax Penalty for Remaining Uninsured.

In order to receive the opt-out bonus of $4,500 or $2,500 (based on your hire date and prorated monthly) you must complete the Waiver of Group Health Benefits Opt-Out Qualification Form attesting that you and your tax dependents are enrolled in minimum essential coverage that is not individual medical insurance.

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/or your dependent(s). However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, please contact your HR Department for further assistance.

BENEFITS FAQ

Q: Can I opt-in/out of enrollment at any time?

A: No employees an only opt-in or opt-out during open enrollment.

Q: What constitutes a qualifying event to opt-in/out?

A: Divorce, loss of employment or death of the spouse who provides benefits for the Fenton employee would qualify as an event that would allow you to opt back in to Fenton benefits. Marriage during the year does not qualify as an event which would allow an employee to opt-out during the year and outside of the open enrollment period. Fenton employees may opt-out only during the open enrollment period, typically between June 1st and 30th of each year.

The new spouse of a Fenton employee may opt-in with proof of marriage if the employee was hired prior to July 1, 2012. Children of those employed prior to July 1, 2012 may be added with proof of birth at any time.

Coverage for a spouse (at the time of marriage) or child (at the time of birth) may be added for those hired after July 1, 2012 if the employee chooses to pay for full coverage through monthly payroll deduction.

The addition of dependents must happen at the time of the qualifying event or during open enrollment.

Q: Can I change providers outside of Open Enrollment?

A: No, employees can only change insurance carriers during Open Enrollment.

Q: If my medication is no longer available through my current medical provider. Can I change providers outside of Open Enrollment?

A: No, employees can only change carriers during Open Enrollment.

Q: If I plan to retire at the end of the school year and I am currently covered by my spouse can I opt in to Fenton's insurance mid-way through the school year in December?

A: As per our retirement policy, the employee should have opted-in in July. The employee needs to opt-in now and return the "in lieu of" payments received to date. The board may need to decide if the employee still qualifies for retirement benefits as the requirement stated below has not been met (retirement coverage may have been forfeited):

Page 86 of the Employee Handbook:

Tiers 1, 2, and 3:

Opt-outs will enroll in the School's plans during the open enrollment period the year prior to the year of retirement.

Q: Can I opt-out of my insurance and keep the stipend if I don't have any other medical coverage?

A: Opting-out may only occur if the employee is under the age of 26 and covered by parents or married and covered by a spouse. If one of these two options is not met, there is no possibility of opting out and no stipend.

If an employee does not have any medical coverage either through a spouse or parent, the employee may not opt-out and receive the stipend.

BENEFITS FAQ CONTINUED

Q: I am covered by my own independent medical plan (i.e. VA health plan) at the time of hire and choose to opt out of the schools plan and keep my own plan, am I eligible to receive the Opt Out stipend?

A: No, employees are only eligible for the Opt-Out stipend if they are covered by a parent (and under the age of 26) or spouse (must provide proof of marriage).

Q: Can I have dual medical coverage (Fenton/Spouse/Independent)?

A: Yes, that is up to the employee.

Q: Can I add my domestic partner (registered or non-registered) as a dependent to my health plan?

A: If hired prior to July 1, 2012, Fenton will pay for a registered domestic partner with documentation.

If hired on or after July 1, 2012, the employee may add the registered domestic partner and pay the full cost of coverage through payroll deduction.

Q: What constitutes a dependent? Who can be added to my medical plan.

A: A dependent may be a spouse or a child under age 26. If the employee was hired prior to July 1, 2012, FCPS will pay for the dependent(s). If the employee was hired after July 1, 2012, the employee may pay full price for the dependents through monthly payroll deductions. Additional information regarding dependent eligibility is on page 7.

Q: If I am a retiree and I move out of state, what options do I have to keep my medical coverage?

A: If the retiree is enrolled in Medicare, the following options apply:

Kaiser Senior Advantage is a California plan, so it is not a possibility for anyone moving out of state.

AARP United Health Care is a national plan and covers the entire country, so this is the plan the Medicare retiree would need to choose.

If the retiree is under age 65 (an early retiree), FCPS is exploring how to deal with this as neither Kaiser nor Health Net are available outside of California.

Q: If I have a Qualifying Life Event and choose to opt out after open enrollment, am I eligible to receive the opt out stipend at that time?

A: No - a qualifying life event only allows a FCPS employee to opt back in to Fenton benefits, not out (i.e, getting married during the year and after the open enrollment period will not allow an employee to opt-out and receive the stipend; the employee must wait until the next open enrollment period).

ELIGIBILITY & ENROLLMENT

Who Can Enroll?

All full-time employees working at least 30 hours per week are eligible for group insurance benefits.

If you are an eligible employee, you may enroll the following dependents:

- Your spouse or registered domestic partner.
- Your children up to age 26, including stepchildren, legally adopted children, children for whom you are the legal guardian, foster children, or children for whom you are legally responsible to provide health coverage under a Qualified Medical Child Support Order (QMCSO). Due to Affordable Care Act, your medical plan covers dependents to age 26.
- Children are eligible for coverage regardless of their student status or whether they live with you.
- Children of children may not be covered unless they meet the plan's dependent eligibility rules as specified above.
- Disabled children over age 26 if unmarried, incapable of self-support, dependent on you for primary support and the disability occurred before the age of 26. Requirements for such coverage and documentation of disability depend on the insurance carrier.

Premiums for domestic partners who do not meet the tax dependent definition of IRS section 152 for the employee, may be considered taxable income (unregistered domestic partners will not meet the relationship test under IRS section 152). Premiums for children/registered Domestic Partners step-children under age 26 are not taxable. Premiums for children/stepchildren over age 26 are taxable if not an IRS section 152 tax dependent.

When Does Coverage Begin?

Your benefits are effective 1st of the month following your date of hire. Once you have completed your new hire waiting period, you must enroll by the deadline date. If you do not enroll within that time period, you will not be eligible for benefits until the next Open Enrollment, unless you have a Qualifying Family Status Change.

Do I have to Enroll?

For information regarding Health Care Reform and the Individual Mandate, please contact HR or visit www.cms.gov/cciio. You can also visit www.healthcare.gov to review information specific to the Health Insurance Marketplace.

You may elect to "waive" medical coverage if you have access to coverage through another plan. It is important to note that if you waive our medical coverage, you must maintain minimum essential health insurance through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans will be during Open Enrollment in 2023 or if a qualifying status change occurs.

ELIGIBILITY & ENROLLMENT

When and How Do I Enroll?

The Paycom enrollment system is available to newly hired employees or during Open Enrollment. Open Enrollment elections will be effective July 1st.

Enrollment is made easy with Ease! You will need your credentials (during the new hire process) to access the benefit enrollment portal.

- Go to https://fentoncharter.ease.com
- Once you are logged into the system, click "Get Started" and complete your profile. Follow the steps to add dependents.
- Make your benefit selection checking off the icon next to the plan to either enroll or waive. Scroll down and click "Continue".
- After selecting your plans you will then sign the electronic enrollment forms.
- Confirm your election summary by clicking "Next". Then, select "Finish".

Ease Mobile App

Download the Ease mobile app to make benefit elections from your phone or tablet, and view your current benefit plans throughout the year!

Qualifying Events

You are permitted to make changes to your benefits outside of the Open Enrollment period if you have a qualified change in status 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 qualified event, not from written notice or proof**. 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 / domestic partner's loss or gain of coverage through our organization or another employer
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace (i.e. Exchange) and it 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 30 days.

Doctors and hospitals may leave or join health plan networks at any time. If your provider leaves your plan's network during the year, this does not qualify as a change in status. As a result, you cannot change your medical coverage.

MEDICAL PLAN OPTIONS

Health Net EOA

If you choose the EOA plan, you must select a primary care physician who will manage your care and refer you to a specialist when it is needed. Most services are covered at 100% after you pay a copayment.

Kaiser HMO

Kaiser operates its own facilities and hires all physicians directly. Most services are provided at little or no cost to the enrollees. Under most circumstances, you must use Kaiser facilities and physicians, although emergency care is covered when you are away from home.

MEDICAL PLANS

WHAT YOU PAY	Elect Open Access POS 20/250 HMO Network	Elect Open Access POS 20/250 PPO Network	Traditional HMO 20/250
Calendar Year Deductible (Single/Family)	No Deductible	No Deductible	No Deductible
Calendar Year Out-of-Pocket Maximum (Single/Family)	$2,500/$7,500	$4,500/$9,000	$1,500/$3,000
Preventive Services	No Charge	No Charge	No Charge
Office Visits (Primary/Specialist/Telehealth)	$20/$40/$0	$40/$40/$0	$20/$20/$0
Lab/X-ray	No Charge	No Charge (Limited to Office Only)	No Charge
Complex Radiology (Includes CT, PET and MRI)	$100	Not Covered	No Charge
Inpatient Hospital Services (Includes maternity)	$250/admission	Not Covered	$250/admission
Outpatient Surgery	Hospital: $250/admission Ambulatory Surgery Center: $100/admission	Not Covered	$20/procedure
Urgent Care (Co-pay waived if admitted)	$40	Not Covered	$20
Emergency Room (Co-pay waived if admitted)	$100	Not Covered	$100
Ambulance	$100	Not Covered	$100
PRESCRIPTION DRUGS			
Calendar Year Drug Deductible	No Deductible	No Deductible	No Deductible
Retail Prescription (Tier 1/Tier 2/Tier 3/Tier 4) (up to 30-day supply	$10/$30/$50/30% up to $250	$10/$30/$50/30% up to $250	$10/$20/ 20% up to $150 (generic/brand/specialty)
Mail-Order Prescription (Tier 1/Tier 2/Tier 3/Tier 4) (up to 90-day supply)	$20/$75/$125/Not Covered	$20/$75/$125/Not Covered	$20/$40 (generic/brand) (up to 100-day supply)

MEDICAL PROVIDER SEARCH

1. Visit www.healthnet.com
2. Click on “Find a Provider” and select a location type from the drop-down menu. Then enter your location details (city & state or zip code).
3. Under “Filter by type of Plan/Network” select “**POS - Elect Open Access Small Group/Large Group”**
4. Click the type of care you are searching for (doctors, urgent cares, hospitals, etc.)

Remember: Provider contracts are always changing with the carrier. Please call your provider or Health Net to ensure that the provider’s are still in-network before going to see them.

1. Visit www.kp.org
2. Click on Doctors & Locations.
3. Choose the Region you are searching in, and enter your zip code.
4. Press “Search” you will get a listing of doctors. Be sure to check the individual doctor bios.

Remember: choosing Kaiser means staying within the Kaiser network, with the limited exception for an approved referral for an outside provider from your PCP.

Looking for Chiropractic or Acupuncture Services?
When you need chiropractic or acupuncture care under the Kaiser HMO plan, you can visit any participating provider in California from the ASH plan network without referral from your HMO PCP. Services must be deemed medical necessary. Find an ASH Plan Participating Provider near you by calling the customer service line at 1-800-678-9133 weekdays from 5am to 6pm (PST) or visiting the website: www.ashlink.com/ash/kp

MEMBER TOOLS

Virtual Visits

When you need care — anytime, day or night — virtual visits can be a convenient option. Talk with a doctor 24/7 about mild conditions such as flus, fevers, colds, sore throats, migraines, rashes, allergies, stomach aches, pink eye, and more.

Mobile App & Member ID Cards

Access the convenient features of the free mobile app offered by your insurance carrier. View details about your plan benefits, search for in-network providers, and view claim history. You can also view an electronic copy of your member ID card.

Member Discounts & Wellness

Being healthy can be affordable, too. Take advantage of healthy discounts and extras included with your health plan to help you live better. Find discounts and perks on a variety of services including fitness and weight loss programs, eye care and hearing aids, health assessments, chiropractor and acupuncture visits, and more.

Care While Traveling

If you get hurt or sick while traveling, you are covered for emergency care anywhere in the world. If you have an emergency while traveling, call 911 or go to the nearest emergency facility. Examples of emergency conditions are shortness of breath, excessive bleeding and severe pain to body parts or organs. If you need routine care while outside of your service area, contact your insurance carrier prior to your travel plans.

*For these and more helpful resources from **Health Net** please scan the QR code!*

*For these and more helpful resources from **Kaiser** please scan the QR code!*

MEDICAL PREVENTIVE SERVICES

The following are examples of Preventive Services covered by your policy. For a complete list of these services, please refer to your combined Evidence of Coverage and Disclosure Form. Preventive Services are covered 100%.

CHILD PREVENTIVE CARE

Screening Tests

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin (blood count)
- HPV screening
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment
- Screening and counseling for STIs
- Vision screening

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza
- Measles, mumps and rubella
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (Chicken Pox)

MEN & WOMEN PREVENTIVE CARE

Men

- Aortic aneurysm screening (men who have smoked)
- Prostate cancer

Women

- Well-woman visits
- Breast cancer testing for BRCA 1 and BRCA 2 when certain criteria are met
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling
- Contraceptive (birth control) counseling
- FDA-approved contraceptive services provided by a doctor
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, iron deficiency, anemia, and STDs
- Pelvic exam and Pap test, including screening for cervical cancer

ADULT PREVENTIVE CARE

Screening Tests

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test
- Obesity
- STIs
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

Immunizations

- Diphtheria, tetanus and pertussis
- Hepatitis A and Hepatitis B
- HPV
- Influenza
- Meningitis
- Measles, mumps and rubella
- Pneumococcal
- Varicella (Chicken pox)
- Zoster (shingles)

DENTAL & VISION PLANS

Delta Dental PPO

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Savings are greater when you visit an in-network provider because contracted dentists have agreed to provide care at a negotiated rate.

If you have services with a non-participating dentist, you will be responsible for the difference between what the plan pays the dentist and the dentist's charges.

VSP Vision

The Vision plan provides professional vision care and high quality lenses and frames through a broad network of specialists. The plan also includes discounts for several lens enhancements and vision services. You will receive richer benefits if you utilize an in-network provider.

If you have services with a non-participating vision provider, you will be responsible for the difference between what the plan will reimburse you and the provider's charges.

DELTA DENTAL PPO PLAN

DELTA DENTAL®

	WHAT YOU PAY	
	In Network*	Out Of Network*
Plan Maximums		
Calendar Year Deductible (single/family)	**No Deductible**	**No Deductible**
Calendar Year Maximum Benefit	**$1,500 per person per calendar year**	
Preventative Procedures		
Oral Examinations, Bitewing or Full Mouth X-rays, Cleanings	**0% (deductible waived)**	**0%** ** **(deductible waived)**
Basic Procedures		
Fillings, Endodontics (root canal therapy), Periodontics, Sealants, Simple Oral Surgery and Simple Extractions	**0%**	**0%**
Major Procedures		
Crowns, Inlays, Onlays and Cast Restorations, Bridges and Dentures	**30%**	**50%**
Orthodontic Procedures		
Orthodontics Lifetime Maximum	**$1,500**	
Orthodontia (Child & Adult)	**50%**	**50%**

***Reimbursement is based on PPO contracted fees for PPO dentists, and maximum allowable charges for non-Delta Dental dentists.*

****Reimbursement based on Delta Dental's Program Allowance. Members may be subject to balance billing.***

Key Facts:

- Free exams, cleanings, & x-rays
- Plan allowance (calendar year maximum benefit) resets every January 1
- Always request a treatment plan before you have services done!

EYEMED VISION PLAN

	WHAT YOU PAY	
	In Network	**Out of Network**
Exams		
Vision Exam (every 12 months)	**$15**	**Reimbursement up to $50**
Lenses		
Single Bifocal Trifocal (every 12 months)	**$15**	**Reimbursement up to:** **$50** **$75** **$100**
Frames		
Frames (every 12 months)	**$150 allowance, then 20% off amount over frame allowance**	**Reimbursement up to $70**
Contacts (In Lieu of Glasses)		
Medically Necessary (every 12 months)	**Covered in Full**	**Reimbursement up to $90**
Elective (every 12 months)	**$140 allowance**	**Not Covered**
Contact lens exam (fitting and evaluation)	**15% discount**	**Not Covered**

Key Facts:

- Services are covered based on your **most recent service date**. You can have a new eye exam and purchase new lenses 12 months after your last eye exam or lens purchase. You can purchase new frames 12 months after your most recent purchase.
- Additional lens enhancements available at a co-pay or discount.
- Out of Network services may require you to make a full payment at the time or services, and submit a claim form for reimbursement.

DENTAL/VISION PROVIDER SEARCH

1. Visit www.deltadentalins.com
2. Click “Find a Dentist” and then enter your Zip Code.
3. Select “Delta Dental PPO” from the “Network” drop-down menu and click “Fins a dentist”.
4. Under the “Refine Search” click on the “Accepting new patients” box and a list of contracted providers that are accepting new patients will be generated

1. Visit https://vsp.com
2. Click “Find a doctor”
3. Enter your zip code or address.
4. Click on “Advanced Search” and select “Signature” from the Doctor Network drop-down menu.
5. Click “Apply Filters” and a list of contracted providers will be generated.

*The **Delta Dental** and **VSP** Mobile Apps are available on the iTunes App Store and Google Play.*

LIFE INSURANCE

All benefit eligible employees are provided with employer-paid Life and Accidental Death & Dismemberment (AD&D) coverage. All eligible employees are automatically enrolled in Life and AD&D plans. This benefit is paid for 100% by your employer.

Employee Basic Life Insurance & Accidental Death and Dismemberment (AD&D)

- Benefit amount of $50,000
- AD&D provides 100% of the Basic Life benefit
- In the event of death that occurs from a covered accident, both Life and AD&D benefit would be payable each in the amount of the basic life insurance.

Benefits Age Reduction

Your life benefits will reduce after a certain age, and the reduction schedule is as follows:

- Reduce to 65% at age 65, reduce to 45% at age 70

- Consider updating your Life Insurance beneficiary through the Ease enrollment portal.
- You may update your Life Insurance Beneficiary any time during the year as often as you would like.

As an added benefit, you may purchase Supplemental Life and Accidental Death & Dismemberment insurance for you and your dependents. This benefit is voluntary and paid for 100% by eligible employees through post-tax payroll deductions.

Supplemental Employee Life/AD&D

Employees may purchase additional coverage in $10,000 increments not to exceed 5 times salary or $500,000. The New Hire Guaranteed Issue* amount is $150,000.

Supplemental Spouse Life/AD&D

You may purchase additional coverage for your spouse in $5,000 increments to the lesser of 100% of employee coverage or $500,000. The New Hire Guaranteed Issue* amount is $25,000.

Supplemental Child(ren) Life/AD&D

You may purchase additional coverage for your child(ren). For children from birth to 6 months, you may purchase $1,000 of coverage. For children from 6 months to 26 years (if full-time student), you may purchase $2,000 increments up to $10,000 of coverage.

Should you choose to elect coverage outside of your initial eligibility period, or you elect coverage above the Guaranteed Issue amount, you or your spouse will need to complete the Evidence of Insurability (EOI) Form for medical underwriting purposes*
www.unum.com/employers/solutions/evidence-of-insurability

DISABILITY INSURANCE

This benefit is paid for 100% by your employer. There is no cost to you, the employee.

All benefit eligible employees are provided with group disability coverage for those unexpected situations that may keep you from performing the daily responsibilities of your job. Your disability plan is available to help supplement your income when you are not able to continue employment for a certain period of time. This benefit is paid for 100% by your employer.

Elimination Period

Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the number of consecutive days you are disabled before you are eligible to receive a benefit.

- **Short Term Disability:** 14-day elimination period.
- **Long Term Disability:** 180-day elimination period.

Coverage Period

Benefits continue for as long as you are considered disabled per the definitions in the plan document.

Benefit Amount

The disability benefit replaces a portion of your basic earnings.

- **Short Term Disability:** 60% of your weekly earnings up to $1,250 per week.
- **Long Term Disability:** 60% of your monthly earnings up to $5,000 per month.

Pre-Existing Condition (Long Term Disability)

Your plan is subject to a pre-existing condition limitation. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention, treatment or medication for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered. Once you have been insured under the plan for 12 months, the pre-existing condition limitation does not apply.

How To Submit A Claim

Obtain a claim form: https://www.unum.com/claims

Start a claim over the phone: (800) 858-6843

Submit a paper claim form:
The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
Fax: (800) 447-2498
Email: askunum@unum.com

VOLUNTARY BENEFITS

These benefits are paid for 100% by the employee.

Group Critical Illness Insurance

What's a critical illness? Some common examples are heart attack, stroke, and cancer. But this coverage also includes serious conditions like permanent paralysis—the kind of injury that can happen to a healthy person in a car or skiing accident, for example. The medical treatment for these conditions can be very expensive. Critical illness insurance can help by paying a lump sum payment directly to you at the first diagnosis of a covered condition. You decide how to spend it. You can use this coverage more than once for different conditions, but each condition is payable once per lifetime.

Benefits:

- Covered critical illnesses: Heart Attack, Stroke, Major Organ Failure, End Stage Kidney Failure, Major Organ Failure, Loss of Sight, Coronary Artery Disease, Cancer, Miscellaneous diagnosis.
- Employee benefit options: $10,000 or $20,000
- Spouse benefit options: $10,000
- Children benefit options: 50% of employee benefit
- $50 Wellness Benefit per insured per calendar year
- Port Option available: you can take your policy with you if you leave your employer
- Each illness is eligible for its own payout

Group Accident Insurance

With the high cost of medical care today, a trip down the stairs can hurt your bank account as much as your body. Accident insurance can pay you money based on the injury and the treatment you receive, whether it's a simple concussion or something more serious, like an injury from a car accident. Your plan can pay you a benefit for an emergency room treatment, stitches, prosthetic devices, injury-related surgery and a list of other accident-related expenses. The money is paid directly to you and you decide how to spend it. You can also purchase coverage for your spouse and dependent children.

Benefits:

- Covers off-the-job accidents 24-hours per day
- Family coverage is available
- Guarantee Issue: No Medical Questions asked
- Port Option available: you can take your policy with you if you leave your employer
- $1,200 combined Hospital Confinement and Hospital Admission benefit

VOLUNTARY BENEFITS

These benefits are paid for 100% by the employee.

Group Voluntary Hospital Indemnity

Hospital Indemnity insurance pays a cash benefit if you or an insured dependent (spouse or child) are confined in a hospital for a covered illness or injury. It also provides additional daily benefits for related services. Even with the best primary health insurance plan, out-of-pocket costs from a hospital stay can add up.

The benefits are paid in lump sum amounts to you, and can help offset expenses that primary health insurance doesn't cover (like deductibles, co-insurance amounts or co-pays), or benefits can be used for any non-medical expenses (like housing costs, groceries, car expenses, etc.).

Benefits:

- Covers on- and off-the-job injury or illness, 24-hours per day
- Family coverage is available
- Guarantee Issue: No Medical Questions asked
- $50 Wellness Benefit per insured per calendar year. (This can be earned through Annual Exams, Dental Exams, Vision Exams, Cancer Screenings, Cardiovascular Function Screenings, Immunizations, etc.)
- Pregnancy covered after 12 months enrolled on the plan.
- Fully portable: you can take your policy with you if you leave your employer

Covered Benefits	Unum Hospital Indemnity Insurance Pays YOU:
Hospital Coverage	
Admission Up to 1 admission per year	$1,500
Confinement	Hospital: $100/day up to 365 days ICU: $100/day up to 30 days
Short Stay	$250 – payable for a maximum of 1 day/year
Health Screening (Wellness) Benefit provided if the covered insured takes one of the covered screening/ prevention tests	$50 - payable 1x per calendar year per covered insured

VOLUNTARY WHOLE LIFE

These benefits are paid for 100% by the employee.

Whole Life Insurance can pay money to your family if you die. It can help them with basic living expenses, final arrangements, tuition and more.

How does it work?

You can keep Whole Life Insurance as long as you want. Once you've bought coverage, your cost won't increase as you age. The benefit amount stays the same, too — it doesn't decrease as you get older. That means you get protection during your working years and into retirement. Whole Life Insurance also earns interest, or "cash value," at a guaranteed rate of 4.5%. You can borrow from that cash value, or you can buy a smaller, paid-up policy — with no more premiums due. Whole Life coverage is available for your spouse, ages 15-80, even if you don't purchase coverage for yourself. Child Term Life benefit up can be added to an employee or spouse policy. Eligible children, legally adopted children and stepchildren are covered from 14 days until the earlier of their 25th birthday or the date your policy ends. At that time, the child has a right to buy an individual Whole Life policy at up to 5 times the amount of their rider.

What's included?

A "Living" Benefit

You can request an early payout of your policy's death benefit (up to $150,000 maximum) if you're expected to live 12 months or less. It would reduce the benefit that's paid when you die.

Benefits:

- Employee benefit options: $6 or $9 weekly
- Spouse benefit options. $3 weekly
- Children benefit options: up to $10,000
- $50 Wellness Benefit per insured per calendar year
- Conversion Option available: you can take your policy with you if you leave your employer

Why should I buy coverage now?

- It's more affordable when you're younger. Once you've bought coverage, your cost stays the same as long as you keep it.
- The cost is conveniently deducted from your paycheck.
- Whole life gives you valuable protection in addition to any term life insurance you might have.

UNUM WELLNESS BENEFIT

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

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

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

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

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

It's easy to file a claim!

You can receive a benefit for tests that are performed after your initial coverage date.

Follow these simple steps:

1. File your claim online with a one-time registration on **unum.com**, by mail or over the phone. Simply call **1-800-635-5597** to learn more.

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

VOLUNTARY LONG TERM CARE

Elimination Period

Your plan's elimination period of 90 consecutive days is the amount of time you must wait before benefits become payable. This time period must be satisfied only once during the life of your plan.

Newly Hired Employees

Once eligible for the plan, you will have 30 days to sign up for the Guarantee Issue coverage.

All Active Employees & Newly Hired Employees

Employees who enroll after the Guarantee Issue enrollment period, choose benefits over the Guarantee Issue limit of $6,000 per month, or enroll in Option 3 below will be required to fill out a medical questionnaire.

Family members may enroll, however, they must complete the Benefit Election Form and Long Term Care Insurance Application (medical questionnaire) and must be approved for coverage in order to enroll in the Long Term Care plan.

Lifetime Maximum

The Lifetime Maximum is the maximum benefit dollar amount Unum will pay over the life of your coverage. This dollar amount is based on the Facility Benefit Amount and Benefit Duration.

Insurance Age

Insurance Age is used to determine the cost of your coverage. If you enroll when you are initially eligible (first of the month following date of hire), your Insurance Age is the age you are when your coverage begins. If you change your plan or wait to enroll outside your initial eligibility, your Insurance Age is your age on the date you sign the application.

Please visit http://unuminfo.com/fentoncharter to view plan details, calculate cost, and obtain enrollment information.

LONG TERM CARE BENEFITS			
PLAN BENEFITS	**OPTION 1**	**OPTION 2**	**OPTION 3**
Benefit Duration	3 Years	6 Years	Unlimited
Home & Community-Based Care Monthly Benefit	$500	$500	$500
Home & Community-Based Care Benefit	50%	50%	50%
Residential Care Facility Monthly Benefit	$1,000	$1,000	$1,000
Elimination Period	90 days	90 days	90 days
Lifetime Maximum	$36,000	$72,000	Unlimited

UNUM TRAVEL ASSISTANCE

Pack your worldwide emergency travel assistance phone number and leave travel worries at home.

If you experienced a medical emergency while traveling, would you know who to call?

Whenever you travel 100 miles or more from home — to another country or just another city — be sure to pack your worldwide emergency travel assistance phone number! Travel assistance speaks your language, helping you locate hospitals, embassies and other "unexpected" travel destinations. Add the number to your cell phone contacts, so it's always close at hand! Just one phone call connects you and your family to medical and other important services 24 hours a day.

Use your travel assistance phone number to access:

- Hospital admission assistance*
- Emergency medical evacuation
- Prescription replacement assistance
- Care and transport of unattended minor children
- Assistance with the return of a vehicle
- Emergency message services
- Critical care monitoring
- Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance
- Transportation for a friend or family member to join a hospitalized patient

One phone call connects you to:

- Multi-lingual, medically certified crisis management professionals
- A state-of-the-art global response operations center
- Qualified medical providers around the world

24/7 services anywhere in the world

Unum's travel assistance services are provided by Assist America, Inc., a leading provider of global emergency assistance services through employee benefit plans. Assist America's medically certified personnel are ready to help 24 hours a day, 365 days a year, and can connect you with pre-qualified, English-speaking and Western-trained medical providers anywhere in the world.

With the Assist America Mobile App, you can:

- Call Assist America's Operation Center from anywhere in the world with the touch of a button
- Access pre-tip information and country guides
- Search for local pharmacies (U.S. only)
- Download a membership card
- View a list of services
- Search for the nearest U.S. embassy
- Read Assist Alerts

Download and activate the app today from the Apple App Store or Google Play.

Reference Number: 01-AA-UN-762490

EMPLOYEE ASSISTANCE PLAN (EAP)

This benefit is paid for 100% by your employer. There is no cost to you, the employee.
All members of your household can utilize the benefits of this program.

Mental health is the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. And when it comes to our health – physical or mental – being proactive and focusing on prevention works!

LifeWorks is here for you any time, day or night, with expert advice to help you adopt strategies that support positive mental health. We can also provide information, resources, and referrals. Contact us 24/7 to speak confidentially with a caring, professional consultant can provide support, referrals, and resources related to many issues, including the following:

- Healthy Living
- Stress Management
- Mental Health
- Diet & fitness
- Overall wellness

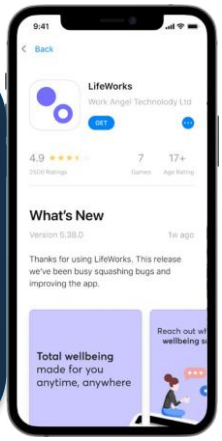
- Parenting support
- Child & elder care
- Learning programs
- Special needs help

- Legal issues
- Will preparation
- Taxes
- Debt
- Financial planning

Along with unlimited telephonic access, the EAP also offers 3-5 face-to-face visits with a counselor per person per situation. Member Services Available 24/7!

Your privacy matters. EAP participation is totally confidential.

Reach out to your EAP 24/7
Toll-free: 1-800-433-7916
En español: 1-800-433-7916
www.login.lifeworks.com
Username: fenton
Password: lifeworks



LifeWorks

Download on the App Store GET IT ON Google Play

Remember: If you're struggling with stress, feeling overwhelmed or overloaded, or worried about your mental health or someone you love, LifeWorks can help. We can talk through your concerns, answer questions, provide guidance, and even refer you to counseling or a helpful community resource.

- **Listen** to audio recordings and podcasts, including recorded relaxation exercises
- **Access** articles to help you learn more about stress management and mental health

VOLUNTARY PET INSURANCE

This benefit is paid for 100% by the employee.

ASPCA offers employees the ability to purchase discounted Pet Insurance. This benefit is voluntary and paid for 100% by eligible employees and paid directly to ASPCA.

ASPCA PET HEALTH INSURANCE
PETS ARE DEPENDENTS, TOO.

What do the plans cover?

ASPCA plans provide nose-to-tail coverage for a wide range of injuries, illnesses, genetic conditions, and emergency care for dogs and cats. Coverage is provided with no claim limits and offers unlimited lifetime benefits with an annual deductible. Multiple discounts are applied at time of rate quote with actual dollar savings presented to the pet parent. The plan co-insurance can cover up to 90% of your veterinary bills.

Refer to the ASPCA website for a complete description of this plan.

How does the benefit schedule work?

Unlimited lifetime benefits are available with no caps on claims. There are some pre-existing conditions on the plans, and the plans do not cover routine care, office visits, or spay/neutering.

How to Enroll

Phone: call 877-343-5314 and tell the pet insurance specialist that you're an employee of Cabrillo Point Academy.

Online: visit the link below to obtain personalized rates. The rates given will include your group discount.

Sign up for these plans any time during the year! Visit:
www.aspcapetinsurance.com/FentonCharter
Save with your priority code: **EB22FentonCharter**

LEGAL & ID THEFT SERVICES

This benefit is paid for 100% by the employee.

Everyone deserves legal protection. And now, with LegalShield, everyone can access it. Proven, professional advice is just a phone call away on all matters, from the trivial to the traumatic. This benefit is voluntary and paid for 100% by eligible employees through post-tax payroll deductions.

The Legal Plan Membership Includes:

- Legal Advice – personal legal issues
- IRS Audit Assistance
- Letters/calls made on your behalf
- Residential Loan Document Assistance
- Trial Defense including Pre-Trial & Trial
- 24/7 Emergency Access for covered situations
- Contracts & documents reviewed (up to 15 pages)
- Moving Traffic Violations (available 15 days after enrollment)
- Attorneys prepare your Will, your Living Will and your Health Care Power of Attorney
- 25% Preferred Member Discount (Bankruptcy, Criminal Charges, Other Matters, etc.)
- Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)

The IDShield[SM] Membership Includes:

- **Full Service Restoration**
  Completed Identity recovery services by Kroll Licensed Private Investigators and our $5 million service guarantee to ensure that if your identity is stolen, it will be restored to its pre-theft status.

- **Privacy Monitoring**
  Monitoring your name, SSN, date of birth, email address (up to 10) provides you with comprehensive identity protection service that leaves nothing to chance.

- **Security Monitoring**
  SSN, credit cards (up to 10), and bank account (up to 10) monitoring, sex offender search, financial activity alerts and quarterly credit score tracking keep you secure from every angle.

- **Consultation**
  Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection.

LegalShield Identity Theft plans cover the member, member's spouse and up to 8 dependents. You also have the option to select Legal plus Identity Theft Combined Membership.

HEALTH INSURANCE MARKETPLACE

Notice of Medical Coverage Options:

THE NEW HEALTH INSURANCE MARKETPLACE

Under federal law, beginning January 1, 2014, individuals will be required to have minimum essential health coverage, or else be subject to a penalty. This is referred to as the "individual mandate." The Health Insurance Marketplace is intended to help individuals meet the individual mandate requirement by providing another marketplace to purchase coverage, and possibly qualify for federal assistance. Individuals who have insurance through their employers (or who are eligible for insurance through their employers) may opt out of the employer plan during their renewal period and go to the Health Insurance Marketplace to purchase health insurance (note employers are not required to pass on their employer contribution towards an employee's coverage election in the Health Insurance Marketplace). Based upon your specific income level and household size, you may receive more affordable coverage for yourself and/or dependents through the Health Insurance Marketplace. Individuals who have insurance through their employers (or who are eligible for insurance through their employers) are not eligible for federal assistance through the individual mandate.

The Health Insurance Marketplace website will help people find out whether they qualify for federal financial assistance that will reduce their costs for medical coverage. Depending on your income and family size, you could be eligible for no-cost Medicare or for tax credits to help reduce your monthly premium costs. You do not need to purchase coverage through the Health Insurance Marketplace if you already have medical coverage. However, you have the option to do so if you wish.

Health Insurance Marketplace

If you have questions, please visit the Health Insurance Marketplace website at **www.healthcare.gov**

Your employer's medical plans meet the affordability and minimal value of coverage tests, and are in full compliance with the requirements of large group employers required by the Affordable Care Act. The medical plans do qualify as coverage required to fulfill individual mandate requirements. Full-time employees and dependents are NOT eligible for tax subsidies through the Health Insurance Marketplace.

IMPORTANT EMPLOYEE NOTIFICATIONS

Disclosure Notice This proposal (analyses, report, etc.) is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal (analyses, report, etc.) is not a contract and offers no contractual obligation on behalf of Gallagher Benefit Services (GBS). Policy forms for your reference will be made available upon request.

Model General Notice of COBRA Continuation You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than 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 is 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 is 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 anyone covered under the Plan who are spouses, dependent children, or anyone else eligible for COBRA continuation coverage under the Plan.

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

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

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.

IMPORTANT EMPLOYEE NOTIFICATIONS

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. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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.

Women's Health & Cancer Rights Act If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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.

Newborns' and Mothers' Health Protection Act Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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.

HIPPA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights Your employer is committed to the privacy of your health information. The administrators of the health plan use strict privacy standards to protect your health information from unauthorized use or disclosure. The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources.

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.

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

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

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

IMPORTANT EMPLOYEE NOTIFICATIONS

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
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: http://flmedicaidtplrecovery.com/hipp/ 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: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	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: http://www.indianamedicaid.com Phone 1-800-403-0864
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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.html 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**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 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: http://www.mass.gov/eohhs/gov/departments/masshealth/ 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/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] 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/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

IMPORTANT EMPLOYEE NOTIFICATIONS

Medicare Part D 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? If you decide to join a Medicare drug plan, your current employer coverage will be affected. For individuals who elect Part D coverage, coverage under the employer plan will end for the individual and all covered dependents. See pages 9–11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan? You should also know that if you drop or lose your current coverage with your employer and do not 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).

Date: July 1, 2022
Name of Entity/Sender: Fenton Charter Public Schools
Office Address: 8928B Sunland Blvd., Sun Valley, CA 91352
Phone Number: (818) 962-3630

HIPAA Special Enrollment Rights

Notice of Your HIPAA Special Enrollment Rights A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

BENEFIT PLAN CONTACT INFORMATION

Provider	Coverage Type	Phone and Web
health net	Medical	Health Net 800-522-0088 **www.healthnet.com**
KAISER PERMANENTE®	Medical	Kaiser 800-464-4000 **www.kp.org**
DELTA DENTAL®	Dental	Delta Dental 888-335-8227 **www.deltadentalins.com**
vsp®	Vision	Vision Service Plan (VSP) 800-877-7195 **www.vsp.com**
unum®	Basic Life /AD&D Supplemental Life/AD&D Long Term Disability Short Term Disability Voluntary Accident Voluntary Critical Illness Voluntary Hospital Indemnity Voluntary Long Term Care Voluntary Whole Life	Unum 800-275-8686 **www.unum.com**
LifeWorks	Employee Assistance Plan (EAP)	LifeWorks 800-433-7916 **www.login.lifeworks.com**
ASPCA® PET HEALTH INSURANCE	Pet Insurance	ASPCA 866-204-6764 **www.aspcapetinsurance.com**
LegalShield® IDShield®	Legal/ID Theft Services	LegalShield/IDShield LegalShield: 800-654-7757 IDShield: 888-494-8519 **www.legalshield.com** **www.idshield.com**

Employee Support Center

Call 855.670.2222

Monday - Friday | 8am - 4pm (PST)

LosAngeles.ESC@ajg.com

Gallagher

Insurance | Risk Management | Consulting

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