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Benefits Guide 2021

Open Enrollment and New Hire

Effective November 1, 2021 - October 31, 2022

Introduction

Welcome

Le Lycée Français de Los Angeles recognizes the importance of having a comprehensive benefits program. Our program is designed to provide you and your family a variety of plans with tools that promote health and wellness. We are committed to making every effort to provide benefits that support the lifestyles and needs of our employees.

Benefit Options for 2021

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

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

- **Medical coverage through Anthem Blue Cross *(New Vivity HMO plan option!)***
- **Dental coverage through Anthem Blue Cross *New!***
- **Vision coverage through Anthem Blue Cross *New!***
- **Basic Life and AD&D coverage through Anthem Blue Cross**
- **Voluntary Life and AD&D coverage through Anthem Blue Cross *New!***
- **Critical Illness and Accident coverage through SunLife**
- **Employee Assistance Program (EAP) through Anthem Blue Cross**

When To Enroll

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

- **When you are newly hired as an employee, your benefit coverage begins on the first of the month following 30 days after your hire date.**
- **During the annual benefits open enrollment period. See page 3.**
- **Within 30 days of a qualifying life event: See page 3 and contact Le Lycée Français de Los Angeles Human Resources Department for more information.**

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

CA Individual Mandate

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

Eligibility

Open Enrollment

Open enrollment occurs once a year. During this time, you may add or remove dependents from your coverage, change your coverage level, or change your benefit elections without experiencing a qualifying event. The benefits and coverage you select during this open enrollment period will remain in effect from November 1, 2021 through October 31, 2022, unless you experience a qualifying life event and submit plan changes.

Eligibility:

Employees:
Full-time employees working 24 hours per week are eligible to participate in the Le Lycée Français de Los Angeles benefit plan.

Dependents:
As an eligible employee, you may cover your legal spouse or registered domestic partner, and dependent child(ren) up to the age of 26 (regardless of their student status).

Qualifying Events for Changing Benefits

If you waive coverage at this time, you cannot enroll in the Le Lycée Français de Los Angeles Health Plan until the next open enrollment period, unless you have a qualifying event. You have 30 days from the time of the qualifying event to notify Human Resources to change your benefits. Examples of qualifying events include:

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

Medical HMO

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

What kind of person should opt for a HMO?

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

Medical PPO

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

What kind of person should opt for a PPO?

If you are looking for greater flexibility to book appointments with providers who are in the PPO network (as well as those out-of-network) without a referral. It's important to note that you may pay a higher rate if you choose to go out-of-network. If you travel often, a PPO plan might be a better fit since they tend to be more flexible– which can be especially helpful if something unexpected happens and you need urgent care.

Dental HMO (DHMO)

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

Dental PPO (DPPO)

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

Frequently Asked Questions

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

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

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

What is a Copay?
A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

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

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

What is In-Network?
Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Coverage to services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.

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

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

Medical Coverage: HMO Options

The following chart summarizes the benefits for the medical plan offered to all eligible employees of Le Lycée Français de Los Angeles. As an eligible employee, you may choose from one of the following plans.

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

	Anthem Classic HMO Select HMO Network	Anthem Classic HMO CA Care Network	Anthem Premier HMO - *New!* Vivity HMO Network
Annual Deductible Calendar year	None	None	None
Annual Out-of-Pocket Max Calendar year	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family	$1,500 Individual $3,000 Family
Physicians Services			
Primary Care	$10 Copay	$10 Copay	$10 Copay
Specialist Visits	$30 Copay	$30 Copay	$10 Copay
Preventive Care	No Charge	No Charge	No Charge
Hospital Services			
Inpatient Hospitalization	$250 Copay	$250 Copay	No Charge
Outpatient Surgery	$125 Copay	$125 Copay	No Charge
Tests			
Advanced Imaging	$100 Copay	$100 Copay	$100 Copay
Diagnostic X-ray/Lab	No Charge	No Charge	No Charge
Urgent / Emergency Care Visits			
Urgent Care	$10 Copay	$10 Copay	$10 Copay
Emergency Room (Waived if admitted)	$100 Copay	$100 Copay	$100 Copay
Prescriptions (Retail 30-day supply)			
Brand Name Rx Deductible	None	None	None
Tier 1: Generic	1a: $5 Copay; 1b: $15 Copay	1a: $5 Copay; 1b: $15 Copay	1a: $5 Copay; 1b: $15 Copay
Tier 2: Preferred Brand Name	$30 Copay	$30 Copay	$30 Copay
Tier 3: Non-Preferred Brand Name	$50 Copay	$50 Copay	$50 Copay
Tier 4: Specialty/ Specialty Drugs	30% up to $250	30% up to $250	30% up to $250
Prescriptions available through mail order. See your summary of benefits for full details.			

Medical Coverage: PPO Option

The following chart summarizes the benefits for the PPO medical plan offered to all eligible employees of Le Lycée Français de Los Angeles. As an eligible employee, you may choose the following plan.

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

	Anthem Classic PPO	
	Prudent Buyer PPO Network	
	In-Network	Out-of-Network
Annual Deductible Calendar Year	$500 Individual $1,500 Family	$1,500 Individual $4,500 Family
Annual Out-of-Pocket Max. Calendar Year	$4,000 Individual $8,000 Family	$12,000 Individual $24,000 Family
Physicians Services		
Primary Care	$30 Copay	40%*
Specialist Visits	$50 Copay	40%*
Preventive Care	No Charge	40%*
Hospital Services		
Inpatient Hospitalization	20%*	40%*
Outpatient Surgery	20%*	40%*
Tests		
Advanced Imaging	20%*	40%*
Diagnostic X-ray/Lab	20%*	40%*
Urgent / Emergency Care Visits		
Urgent Care	$30 Copay	40%*
Emergency Room (Waived if admitted)	$150 Copay + 20%	Same as In-Network
Prescriptions (Retail 30-day supply)		
Brand Name Rx Deductible	None	None
Tier 1: Generic	1a: $5 Copay; 1b: $15 Copay	50% up to $250
Tier 2: Preferred Brand Name	$30 Copay	50% up to $250
Tier 3: Non-Preferred Brand Name	$50 Copay	50% up to $250
Tier 4: Specialty/Specialty Drugs	30% up to $250	50% up to $250
Prescriptions available through mail order. See your summary of benefits for full details.		

* After Deductible

A member-first experience

Our focus is on our members and what they need — as healthcare should be. The doctors, medical centers, and hospitals in the Vivity network work hard to ensure you receive the best-quality healthcare, at an affordable cost.

Choosing quality care

When people are more involved in their health, it leads to better outcomes.[1] With Vivity, **you have your choice** of primary care physician (PCP) to serve as your main doctor and handle things like annual exams and preventive care. The PCP will be part of a medical group or an independent practice association (IPA):

- A medical group is a team of doctors who have come together as partners. They usually share one office or building and work together to care for patients. You can often fill prescription medicines and have lab tests, X-rays, and other services in the same building.
- An IPA is a group of independent doctors in the network. They have their own offices and see different patients but have joined together to create an IPA.

Removing restrictions

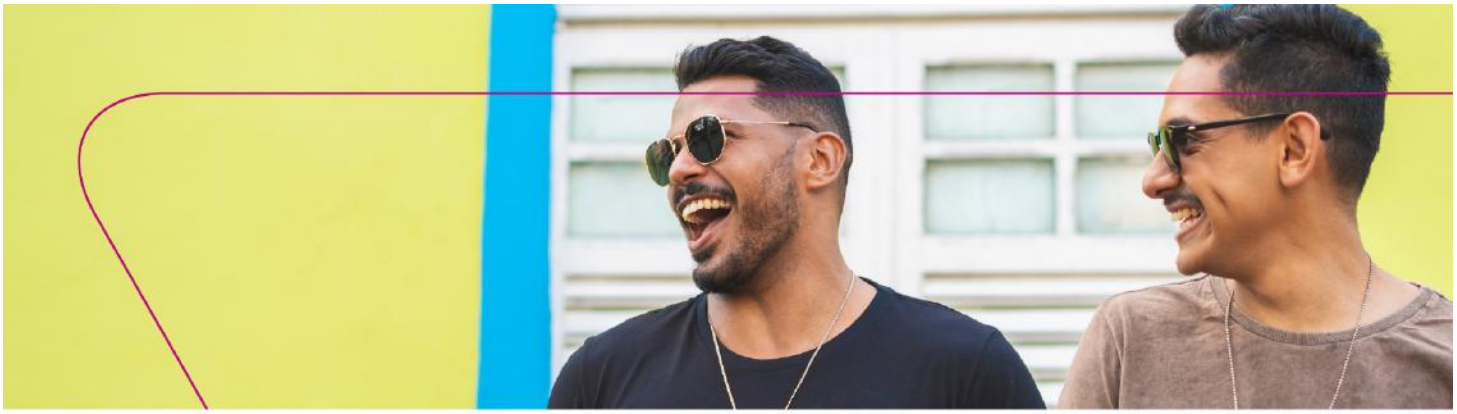
While you have your choice for primary care, you are also **not restricted to a particular medical group.** To make the healthcare journey simpler, Vivity allows you to ask your PCP for a referral to any specialty in the network — and also go directly to certain specialists without preapprovals. Removing the need for preapprovals for certain specialty care saves you time, puts you in control of whom you see, and helps ensure you receive the care you need.[2]

There are **three ways to see a specialist:**

- Through *Direct Access*, you can refer yourself to dermatologists; ear, nose, and throat doctors; OB-GYNs; and allergists in your medical group. You do not need a referral from your PCP.[3]
- With *Speedy Referral*, your doctor can refer you to certain types of specialists without preapproval:
  - Allergist — care for allergies
  - Cardiology — heart health
  - Dermatology — skin care
  - Ear, nose, and throat (ENT) — care for head and neck
  - Endocrinology — gland health
  - Gastroenterology — stomach, intestines, digestion
  - Hematology — focus on blood
  - Neurology — brain and nerve health
  - Obstetrics/gynecology — pregnancy, women's health
- ★ **Unique to Vivity,** *Physician Directed Access* offers more choice and access to doctors by letting you request care from a specialist in a different health system in the network. While traditional health maintenance organizations (HMOs) limit members to receiving care from a specific medical group, Vivity members have more freedom. When you want to see a specialist outside of your medical group, the PCP can refer you to one in another medical group within the network.

We can help you find a doctor

You can search for doctors in the Vivity plan using our mobile app or by visiting **vivityhealth.com/join.**



You have even more options when you need care:

- ★ **Unique to Vivity,** *urgent care access* lets you can go to any urgent care in the Vivity network. You will only have to pay your copay for care. You do not need to pay the full amount for care upfront.
- ★ **Unique to Vivity,** the *away-from-home access* benefit is available within the state of California. For example, if you live in Southern California but have college students in Northern California, they will be covered. This benefit is usually only available to out-of-state students.

Making access to care easier

A flat-fee system, called a copay, makes payments predictable. You pay a copay when you receive care, and Vivity pays the rest. There are no deductibles or hidden costs.

Many network doctors offer **evening and weekend office hours** for convenience. You can have **virtual visits with a PCP** by using each health system's telehealth option. For added convenience, you can have **video visits with a doctor 24/7 through LiveHealth Online** for the same copay as an office visit. You can access doctors on LiveHealth Online — or a therapist or psychiatrist through LiveHealth Online Psychology — by using a smartphone, tablet, or computer. The doctors can assess symptoms, provide a treatment plan, and send a prescription to a pharmacy, if needed.[4] There are also Spanish-speaking doctors available.

Registered nurses are also available by phone for **support and answers to health questions, day or night**, through 24/7 NurseLine.

If you need prescription medicines, you can choose to pick them up at a pharmacy near you that's in the network or have the drugs sent to you through our home delivery pharmacy.

On the **vivityhealth.com** website, you can choose your PCP, find a behavioral health specialist, see each health system's service areas, and access answers to common questions about each health system.

The **free mobile app** empowers you through features such as tap to call, access to digital ID cards and coverage information, telehealth visits, online health assessments, and coaching and wellness messages. Through the app, which is available at the App Store® or Google Play™, you can also access your doctor's patient website and find urgent care centers in the network. The app is also available for computers.

To help encourage you to be and stay your healthiest, we offer a variety of **wellness programs at no extra cost**, such as:

- *MyHealth Advantage*: confidential, personalized health reminders and tips mailed to you
- *ConditionCare*: special health support to manage diabetes, asthma, chronic obstructive pulmonary disease (COPD), or a heart condition
- *Future Moms*: program to help with a healthy pregnancy and delivery

Enhanced member service

Vivity's focus on your needs starts before you even become a member.

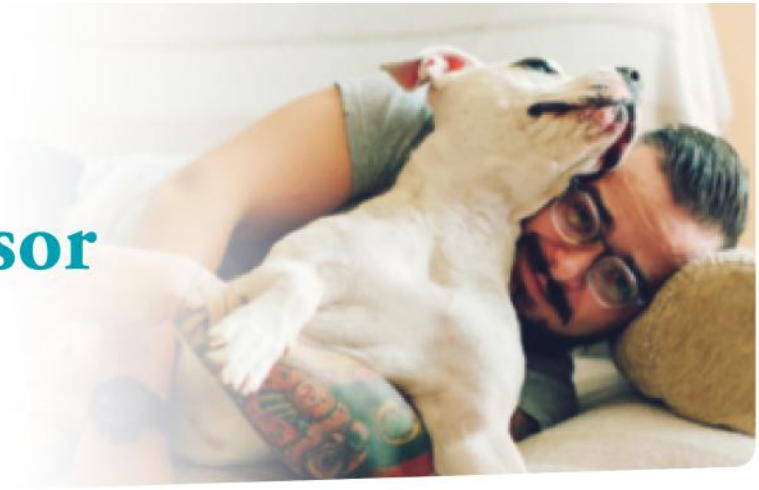
The First Impressions team is there to help during open enrollment. They also help when you join Vivity if you need assistance moving from your current health plan or need care before you receive your ID cards.

After that, you will receive **support from a specially trained concierge team** that's available by phone. The Vivity Concierge helps you manage your plan and your health. The team can:

- Find doctors and specialists.
- Help with drug list questions and preapprovals.
- Answer questions about costs.
- Connect you to case management and condition care programs.

The Vivity Concierge is available at 844-4-VIVITY (844-484-8489), Monday through Friday, 8 a.m. to 8 p.m.

Resource Advisor is here to help



Resource Advisor, a member assistance program that's included with your life and/or disability benefit, provides resources and services to support you and your household family members when you need it.

Counseling by phone, face-to-face or LiveHealth Online video chat

When you're feeling stressed, worried or having a tough time, you may want someone to talk to. You and your household family members can call Resource Advisor anytime, 24/7, and talk with a licensed counselor:

- **By phone**: Call **1-888-209-7840**.
- **In-person**: Call to set up face-to face sessions and then schedule with your counselor.
- **Video chat**: Talk with a counselor from the convenience of your home or wherever you have internet access and privacy using LiveHealth Online. To set up a LiveHealth Online visit, call Resource Advisor. We'll give you details about how to schedule a visit, along with a coupon code that gives you LiveHealth Online visits at no extra cost to you.

You can also review a therapist's background and qualifications to help choose one who's available and right for you. Whatever works for you — we're here to help with any concern, no matter how big or small.

You and your family members are eligible for up to three counselor visits for each issue or concern, at no cost to you.

Counselors can help with:

- Stress
- Parenting
- Anxiety
- Depression
- Any issue that affects your wellbeing
- Dealing with illness
- Relationship or family issues
- Finding child care
- Elder care issues and resources

Resource Advisor
1-888-209-7840

www.ResourceAdvisorCA.anthem.com
(Log in with program name ResourceAdvisor.)

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Anthem

Anthem

Say hi to Sydney

Anthem's new app is simple, smart and all about you

Everything you need to know about your Anthem benefits — personalized and all in one place.

With Sydney, you'll enjoy a simpler, more connected health experience.

Get started with Sydney

Download the app today!

GET IT ON Google Play

Download on the App Store

GOOD HEALTH IS **WORTH IT**

Your guide to earning rewards with Wellbeing Solutions

Your whole health matters. That's why you have Wellbeing Solutions, a suite of programs to help you with your everyday health and well-being. You receive extra guidance and support in managing your health, plus you can earn monetary rewards.

Earn up to **$200 in rewards**

Anthem Health Rewards[1] offers you and your covered spouse or partner up to $200 in rewards for taking part in employer-sponsored health and wellness programs. You will receive your rewards through a reloadable debit rewards card or an account deposit.[2] You can see the status of your progress on anthem.com/ca or download the free Sydney Health mobile app.

Includes

Well-being Coach[3]

Well-being Coach offers multiple options to help you meet your well-being goals. Our digital coaching app offers personalized 24/7 support on the go, whenever you need it. Well-being Coach combines smart technology and proven behavioral therapy techniques to help you maintain a healthy weight or quit tobacco. You can also receive additional help on well-being topics like nutrition, activity, mindfulness and sleep. Well-being Coach is powered by Lark and accessible from the Sydney Health app.

If you prefer a helping hand or require additional support meeting your health goals, Well-being Coach gives you access to a certified Health Coach by phone. You and your coach will identify habits you want to change and develop custom action plans to achieve your health goals. No matter how you connect, you can earn rewards with Well-being Coach.

Rewards you can earn (up to $200 total)

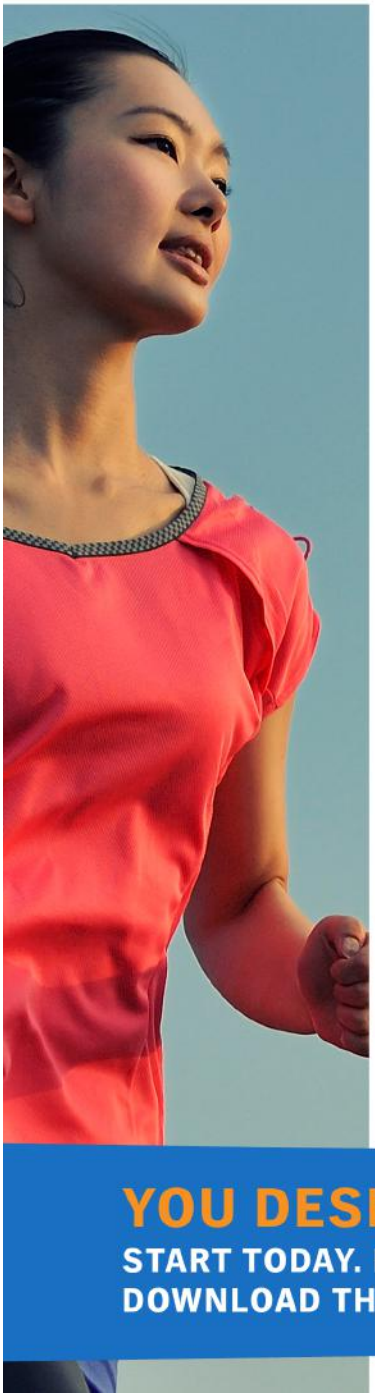
Flu shot and wellness visit reward - up to $50

For extra motivation to stay healthy, you can earn $50 in rewards for receiving a claims-based annual preventive wellness exam and flu shot.

Visit your primary care doctor's office for your wellness exam. You can also receive a flu shot at your doctor's office, or at a pharmacy or retail clinic. Your wellness exam or flu shot do not need to be completed in any particular order or together. Be sure to submit the claims to Anthem or ask your doctor or other provider to submit them to Anthem for you.[4]

My Health Rewards Activities - up to $150

Keep up healthy habits by tracking your activity through anthem.com/ca, Sydney Health or the Well-being Coach app. You can also track rewards activities through a variety of devices, such as Apple Health Kit, Google Health, and more. Go to the Help section of Sydney Health for a full list of supported devices.



Sydney Health Activities

- Login to website or mobile app - 10 points / yearly
- Connect a tracking device - 15 points / yearly
- Complete the WebMD Health Risk Assessment - 75 points / yearly
- Read five articles or watch five videos - 25 points / yearly (5 points earned at a time)
- Article/video topics include: exercise, healthy eating, sleep, family health, mind & body, what's new, trending, and more
- Set an action plan - 10 points / once per quarter
- Action plans include: Eat Healthy, Achieve a Healthy Weight, Get Active, Increase Energy, Reduce Stress and Sleep Better
- Complete an action plan - 100 points / once per quarter
- Track steps
  - Average 2,000 steps a day - 2 points / monthly
  - Average 5,000 steps a day - 5 points / monthly
  - Average 7,500 steps a day - 10 points / monthly

Well-being Coach Activities

- First completed Mission daily check-in - 10 points
- Achieve 15 completed Mission daily check-ins during the first three months - 15 points
- Achieve 25 completed Mission daily check-ins during the second three months - 25 points
- Achieve 25 completed Mission daily check-ins during third three months - 25 points
- Achieve 25 completed Mission daily check-ins during fourth three months - 25 points

You will receive a reward payout when you reach the milestones of 100, 200 and 300 points. One hundred points equals $50.

Example: First, you receive a reward payout when you reach the 100 point milestone. Then, your points balance resets to zero. To reach the next milestone, you will need to earn 200 points. When you reach this 200 point milestone, you receive a reward payout and your points will reset again to zero. To receive the final reward payout, you will need to earn another 300 points.

Dental Coverage

The following chart summarizes the benefits for the dental plan(s) offered to all eligible employees of Le Lycée Français de Los Angeles. As an eligible employee, you may choose from one of the following plans.

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

	Anthem DHMO	Anthem DPPO	
		In-Network*	Out-of-Network*
Benefit Description & Procedure Code			
Annual Deductible Individual/Family	None	$50 / $150	$50 / $150
Annual Maximum Benefit** Individual	Unlimited	$1,500	$1,500
Preventive & Diagnostic Services			
Periodic Oral Evaluation D0120	No Charge	Plan 100%; You 0%	Plan 100%; You 0%^
Prophylaxis (Cleaning) D1110	No Charge	Plan 100%; You 0%	Plan 100%; You 0%^
Bitewing X-rays D0272	No Charge	Plan 100%; You 0%	Plan 100%; You 0%^
Basic Services			
Amalgam Restoration (Filling) one surface D2140	No Charge	Plan 80%; You 20%	Plan 80%; You 20%^
Gingivectomy per quad (1 to 3 teeth) D4211	$10 Copay	Plan 80%; You 20%	Plan 80%; You 20%^
Root Canal D3310	$45 Copay	Plan 80%; You 20%	Plan 80%; You 20%^
Major Services			
Porcelain Crown D2750	$95 Copay	Plan 50%; You 50%	Plan 50%; You 50%^
Orthodontic Benefits			
Orthodontic Benefits - Child and Adult	$1,695 / $1,895	Child: 50% / Adult: N/A	Child: 50% / Adult: N/A
Orthodontic Lifetime Maximum Benefit	N/A	$1,500	$1,500

* Only partial coverage details provided above. For full in-network and out-of-network plan details, please review the benefit summaries and Evidence of Coverage booklets.
** Annual Maximum is based on the calendar year.

^ Members are subject to charges above the allowed OON reimbursable charge since services are rendered by non-contracted providers. This is called balance billing.

Dental HMO (DHMO)

If you elect DHMO coverage, you must select a contracted dentist from the DHMO Provider list. All care must be provided by the primary dentist.

Vision Coverage

The following chart summarizes the benefits for the vision plan offered to all eligible employees of Le Lycée Français de Los Angeles.

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

	Anthem Blue View Vision - *New!*	
	In-Network	Out of Network
Basic Eye Exam	$10 Copay	Plan pays up to $42
Frames	$130 Allowance	Plan pays up to $45
Single Vision Lenses	$25 Copay	Plan pays up to $40
Bifocal Lenses	$25 Copay	Plan pays up to $60
Trifocal Lenses	$25 Copay	Plan pays up to $80
Medically Necessary Contacts (in lieu of frames)	Covered 100%	Plan pays up to $210
Elective Disposable Contact Lenses (in lieu of frames)	$130 Allowance	Plan pays up to $105
Eye Exam Benefit Frequency	Once every 12 months	Same as In-Network
Frame Benefit Frequency	Once every 24 months	Same as In-Network
Lenses Benefit Frequency	Once every 12 months	Same as In-Network

Life & AD&D Coverage

Basic Life and AD&D Coverage

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

EMPLOYER PROVIDED LIFE INSURANCE	EMPLOYER PROVIDED ACCIDENTAL DEATH & DISMEMBERMENT
$25,000	$25,000

The reduction schedule is: 35% at age 65 and 50% at age 70.
With this benefit you also receive Beneficiary Services, Travel Assistance, Resource Advisor, Special Offers, and Child Education Benefit.

Voluntary Life and AD&D Coverage - *New!*

As an employee of Le Lycée Français de Los Angeles, you have the option of purchasing additional life and AD&D coverage through Anthem Blue Cross. This voluntary policy enables you to purchase coverage for yourself, and qualified dependents. When you enroll yourself and your dependents in this benefit, you pay the full cost through post-tax payroll deductions.

	Employee	Spouse/DP	Child(ren)*
Coverage Option	Increments of $10,000	Increments of $5,000	Increments of $5,000, not to exceed $10,000
Guarantee Issue Amount	$100,000	$250,000	All Amounts
Maximum Amount	$300,000 or 5x annual earnings, whichever is less	$150,000	$10,000

*Coverage begins at 15 days from birth up until they reach age 26.

Employee Assistance Program

Employee Assistance Program (EAP)

Just when you think you have it figured out, along comes a challenge! Whether those challenges are big or small, your EAP Support Program is available to help you and your family find a solution and restore peace of mind.

Call Anthem any day, any time. Support is just a phone call away whenever you need support– at no additional cost to you. An advocate is ready to help assess your needs and develop a solution to help resolve your concerns. Advocates can also direct you to an array of resources in your community and online tools. Call for a referral to a service in your community, or advice on topics such as:

- **Legal consultation:** Receive help and guidance with legal issues and financial problems
- **Parenting:** Receive guidance on child development, sibling rivalry, separation anxiety and much more.
- **Senior care:** Learn about challenges and solutions associated with caring for an aging loved one.
- **Child care:** Whether you need care all day or just after school, find a place that's right for your family.
- **Temporary back-up care:** Don't let an unplanned event get the best of you – find back-up child care

For more information and to reach out for support, please call (888) 209-7840, or visit www.ResourceAdvisorCA.anthem.com. Log in with program name, ResourceAdvisor.

Voluntary Products

At Le Lycée Français de Los Angeles eligible employees are offered the option to enroll in two additional benefits; Critical Illness coverage and Accidental Injury coverage. Both benefits offer portability options. In the event of serious illness or accident, Sun Life gives you more ways to protect yourself, your family, and your assets. Below is a brief summary of the plans. Please review the full benefit summaries and plan documents for more detailed information.

Critical Illness Coverage

The **Critical Illness** plan is designed to help employees offset the financial impact of a catastrophic illness with lump sum benefits if an insured is diagnosed with a covered critical illness. All employees are eligible to enroll with no Evidence of Insurability (EOI). The benefit amount is based on the coverage in effect on the date of diagnosis, or the date treatment is received according to the terms and provisions of the policy. Thus, please refer to the full benefit summary for examples of covered illness & payouts.

Voluntary Benefit Amounts:

Employee: May range from $5,000 to $50,000 in $5,000 increments
Spouse: May range from $2,500 to $25,000 in $2,500 increments
Dependent Child: May range from $2,500 to $5,000 in $2,500 increments

Pay Out Examples:

Heart Attack: 100% of elected amount
Stroke: 100% of elected amount
Coronary Artery Bypass Surgery: 25% of elected amount
Coma: 100% of elected amount
Blindness: 100% of elected amount
Diagnosis of Invasive Cancer: 100% of elected amount

Accident Coverage

The Accidental Injury plan is designed to help covered employees meet their out-of-pocket expenses and extra bills caused by an accidental injury, whether minor or catastrophic. Lump sum benefits are paid directly to the employee and their covered spouse and/or children based on the amount of coverage listed in the schedule of benefits.

Coverage Amounts:

Employee: $25,000
Spouse: $25,000
Dependent Child: $5,000

Coverage Pay Out Examples:

Emergency Room: $150
Concussion: $100
Dislocation: Varies by type and location
Fracture: Varied by type and location
Initial Hospital Admission: $1,000/$1,500
Hospital Confinement: $250/$500 per day

BENEFIT ADVOCATE

BOLTON & COMPANY

For assistance with your Medical, Dental, Vision, Basic Life/AD&D, Voluntary Life/AD&D, Worksite, and Employee Assistance Program benefit questions.

Le Lycée Français de Los Angeles

Phone: (855) 206-1255 (toll free)
Email: LyceeLABenefits@boltonco.com
Availability: 9:00am – 5:00pm PT Monday - Friday

Who are the Benefit Advocates?

- Benefit Advocates are highly-trained professionals with extensive insurance industry experience who are available to assist you with your benefit needs.

When should you call your Benefit Advocate?

- Insurance claim questions
- Appeal of denied claims if warranted
- Benefit questions and clarifications
- Prescription problems

What you will need to provide your Benefit Advocate or the insurance carrier in order to receive assistance?

- Member ID Number or Social Security number
- Date of birth
- Your Employer's Name
- An itemized bill of services from your provider, or an explanation of benefits (EOB) from the carrier
- HIPAA Authorization form may be requested

When should you contact your health insurance carrier directly?

- To request a new or additional ID card
- For the initial submission of claims
- To verify your physician is in the network

Important Notices

Notice: Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, see the contact information at the end of these notices.

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

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

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

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

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the end of these notices.

Notice: Consolidated Omnibus Budget Reconciliation Act (COBRA)

Introduction

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

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

You may have other options available to you when you lose group health coverage.

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Continuation Coverage Available?

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

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

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

How is COBRA Continuation Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

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

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employees, after the Medicare initial emrollment period, you have 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact information at the end of these notices. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

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

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

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

REEMPLOYMENT RIGHTS

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

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

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

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

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

then an employer may not deny you:

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

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

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

ENFORCEMENT

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

Notice: Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, **www.healthcare.gov**.
If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **(877) KIDS-NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored Plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **(866) 444-EBSA(3272)**.
If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – MEDICAID
WEBSITE: http://www.myalhipp.com **PHONE: (855) 692-5447**	**WEBSITE:** **HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM** **http://dhcs.ca.gov/hipp** **PHONE: (916) 445-8322** **EMAIL: hipp@dhcs.ca.gov**
ALASKA – Medicaid	**COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)**
El Programa de Pago de Alaska primas del seguro médico **WEBSITE: http://myakhipp.com/** **PHONE: (866) 251-4861** **EMAIL: CustomerService@MyAKHIPP.com** **MEDICAID ELIGIBILITY:** **WEBSITE: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	**Health First Colorado Website: https://healthfirstcolorado.com/** **Health First Colorado Member Contact Center:** **(800) 221-3943 / State Relay 711** **CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus** **CHP+Customer Service: (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: (855) 692-6442**
ARKANSAS – MEDICAID	**FLORIDA – MEDICAID**
WEBSITE: http://myarhipp.com/ **PHONE: (855) MyARHIPP (855-692-7447)**	**WEBSITE:** **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** **PHONE: (877) 357-3268**
GEORGIA – MEDICAID	**LOUISIANA – MEDICAID**
WEBSITE: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** **PHONE: (678) 564-1162 EXT. 2131**	**WEBSITE: www.medicaid.la.gov or www.ldh.la.gov/lahipp** **MEDICAID HOTLINE: (888) 342-6207** **LAHIPP PHONE: (855) 618-5488 (LaHIPP)**

INDIANA – MEDICAID	MAINE – MEDICAID
HEALTHY INDIANA PLAN FOR LOW-INCOME ADULTS 19-64 WEBSITE: http://www.in.gov/fssa/hip/ PHONE: (877) 438-4479 ALL OTHER MEDICAID WEBSITE: https://www.in.gov/medicaid/ PHONE: (800) 457-4584	ENROLLMENT WEBSITE: https://www.maine.gov/dhhs/ofi/applications-forms PHONE: (800) 442-6003 TTY: Maine Relay 711 PRIVATE HEALTH INSURANCE PREMIUM WEBPAGE: https://www.maine.gov/dhhs/ofi/applications-forms PHONE: (800) 977-6740 TTY: Maine Relay 711
IOWA – MEDICAID AND CHIP (HAWKI)	**MASSACHUSETTS – MEDICAID AND CHIP**
MEDICAID WEBSITE: https://dhs.iowa.gov/ime/members PHONE: (800) 338-8366 HAWKI WEBSITE: http://dhs.iowa.gov/hawki PHONE: (800) 257-8563 HIPP WEBSITE: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	WEBSITE:https://www.mass.gov/info-details/masshealth-premium-assistance-pa PHONE: (800) 862-4840
KANSAS – MEDICAID	**MINNESOTA – MEDICAID**
WEBSITE: https://www.kancare.ks.gov/ PHONE: (800) 792-4884	WEBSITE:https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp PHONE: (800) 657-3739
KENTUCKY – MEDICAID	**MISSOURI – MEDICAID**
KENTUCKY INTEGRATED HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (KI-HIPP) WEBSITE: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx PHONE: (855) 459-6328 EMAIL: KIHIPP.PROGRAM@ky.gov KCHIP WEBSITE: https://kidshealth.ky.gov/Pages/index.aspx PHONE: (877) 524-4718 KENTUCKY MEDICAID WEBSITE: https://chfs.ky.gov	WEBSITE: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm PHONE: (573) 751-2005
MONTANA – MEDICAID	**NORTH DAKOTA – MEDICAID**
WEBSITE: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP PHONE: (800) 694-3084	WEBSITE: http://www.nd.gov/dhs/services/medicalserv/medicaid/ PHONE: (844) 854-4825
NEBRASKA – MEDICAID	**OKLAHOMA – MEDICAID AND CHIP**
WEBSITE: http://www.ACCESSNebraska.ne.gov PHONE: (855) 632-7633 LINCOLN: (402) 473-7000 OMAHA: (402) 595-1178	WEBSITE: http://www.insureoklahoma.org PHONE: (888) 365-3742
NEVADA – MEDICAID	**OREGON – MEDICAID**
MEDICAID WEBSITE: https://dhcfp.nv.gov/ MEDICAID PHONE: (800) 992-0900	WEBSITE: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html PHONE: (800) 699-9075
NEW HAMPSHIRE – MEDICAID	**PENNSYLVANIA – MEDICAID**
WEBSITE: https://www.dhhs.nh.gov/oii/hipp.htm PHONE: (603) 271-5218 TOLL FREE NUMBER FOR THE HIPP PROGRAM: (800) 852-3345 Ext. 5218	WEBSITE: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx PHONE: (800) 692-7462
NEW JERSEY – MEDICAID AND CHIP	**RHODE ISLAND – MEDICAID AND CHIP**
MEDICAID WEBSITE: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ MEDICAID PHONE: (609) 631-2392 CHIP WEBSITE: http://www.njfamilycare.org/index.html CHIP PHONE: (800) 701-0710	WEBSITE: http://www.eohhs.ri.gov/ PHONE: (855) 697-4347 or (401) 462-0311 (Direct Rite Share Line)

NEW YORK – MEDICAID	SOUTH CAROLINA – MEDICAID
WEBSITE: https://www.health.ny.gov/health_care/medicaid/ **PHONE: (800) 541-2831**	**WEBSITE: https://www.scdhhs.gov** **PHONE: (888) 549-0820**
NORTH CAROLINA – MEDICAID	**SOUTH DAKOTA - MEDICAID**
WEBSITE: https://medicaid.ncdhhs.gov/ **PHONE: (919) 855-4100**	**WEBSITE: http://dss.sd.gov** **PHONE: (888) 828-0059**
TEXAS – MEDICAID	**WASHINGTON – MEDICAID**
WEBSITE: http://gethipptexas.com/ **PHONE: (800) 440-0493**	**WEBSITE: https://www.hca.wa.gov/** **PHONE: (800) 562-3022**
UTAH – MEDICAID AND CHIP	**WEST VIRGINIA – MEDICAID**
MEDICAID WEBSITE: https://medicaid.utah.gov/ **CHIP WEBSITE: http://health.utah.gov/chip** **PHONE: (877) 543-7669**	**WEBSITE: http://mywvhipp.com/** **TOLL-FREE PHONE: (855) MyWVHIPP (699-8447)**
VERMONT– MEDICAID	**WISCONSIN – MEDICAID AND CHIP**
WEBSITE: http://www.greenmountaincare.org/ **PHONE: (800) 250-8427**	**WEBSITE:** **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** **PHONE: (800) 362-3002**
VIRGINIA – MEDICAID AND CHIP	**WYOMING – MEDICAID**
WEBSITE: https://www.coverva.org/en/famis-select **https://www.coverva.org/hipp/** **MEDICAID PHONE & CHIP PHONE: (800) 432-5924**	**WEBSITE: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** **PHONE: (800) 251-1269**

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

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

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

For more information, contact:

Name: Jasmine Barsoumian
Title: Accountant
Address: 3261 Overland Ave., Los Angeles, CA 90034-3589
Telephone Number: (310) 836-3464 ext.314
Email: accounting@lyceela.org

Notice: Patient Protection –Primary Care Designation (HMO)

Your group health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your health insurer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, see the contact information at the end of these notices.

Notice: Patient Protection –Obstetrics & Gynecological care (HMO)

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

Notice: HIPAA Notice of Privacy Practice

Your Information. Your Rights. Our Responsibilities.

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

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

Your Rights

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

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

Your Choices

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

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

Our Uses and Disclosures

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

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

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

How else can we use or share your health information?

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

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

Our Responsibilities

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

Changes to the Terms of this Notice

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

Effective date of this Notice

January 1, 2021

Employee Contributions

	Monthly Payroll Deductions			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical				
Anthem Premier HMO (Vivity)	$143.25	$879.65	$634.16	$1,431.93
Anthem Classic HMO (Select)	$156.80	$909.39	$658.56	$1,473.87
Anthem Classic HMO (CA Care)	$369.81	$1,377.98	$1,041.93	$2,134.18
Anthem PPO	$697.75	$2,099.50	$1,632.26	$3,150.81
Dental & Vision				
Anthem Dental HMO	$3.07	$15.37	$17.22	$32.84
Anthem Dental PPO	$41.85	$94.97	$116.91	$179.46
Anthem Vision	$0	$5.90	$7.33	$14.91
Life				
Anthem Basic Life & AD&D	$0	N/A	N/A	N/A
Anthem EAP Resource Advisor	$0	$0	$0	$0
Voluntary Benefits				
Sun Life Voluntary Critical Illness	Rates in ADP	Rates in ADP	Rates in ADP	Rates in ADP
Sun Life Voluntary Accident Insurance	Rates in ADP	Rates in ADP	Rates in ADP	Rates in ADP

Carrier Contact Info

Administrator	Benefit	Phone	Website
Anthem Blue Cross	EAP/Resource Advisor	(888) 209-7840	www.resourceadvisor.anthem.com
Anthem Blue Cross	Medical HMO	(855) 383-7248	www.anthem.com/ca
Anthem Blue Cross	Medical HMO - Vivity Concierge	(844) 484-8489	www.vivityhealth.com
Anthem Blue Cross	Medical PPO	(855) 383-7248	www.anthem.com/ca
Anthem Blue Cross	Dental HMO	(800) 627-0004	www.anthem.com/ca
Anthem Blue Cross	Dental PPO	(877) 567-1804	www.anthem.com/ca
Anthem Blue Cross	Vision	(866) 723-0515	www.anthem.com/ca
Anthem Blue Cross	Life	(800) 552-2137	www.anthem.com/ca
Bolton	Benefit Advocate Line	(855) 206-1255	lyceelabenefits@boltonco.com
Sun Life	Accident & Critical Illness	(800) 733-7879	www.mysunlifebenefits.com

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