

EMPLOYEE BENEFITS GUIDE

2025–2026

HSD

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As a valued employee of Hawthorne School District, your health and quality of health and quality of life are important to us. We offer benefits designed to help you improve your health and handle those challenges that life sometimes presents. This brochure provides a summary of benefit options offered by Hawthorne School District. If you would like more information about any of the benefits described here, please contact the Benefit Department.

ENROLLMENT INFORMATION

All employees and their eligible dependents may participate in the Hawthorne School District benefit programs. Your eligible dependents include:

- Legally married spouse
- Registered domestic partners
- Children under 26 regardless of student or marital status

Eligible employees may enroll at the following times:

- As a new hire, you may participate in the district's benefits program on the first day of the month following your date of hire
- During annual open enrollment
- Within 31 days of a qualified change in family status as defined by the IRS (see changes to enrollment)

Paying for your coverage

You and the District share in the cost of the Medical, Dental, and Vision benefits you elect. Your Medical, Dental, and Vision contributions are deducted before taxes are withheld, which saves you tax dollars. Paying for your benefits before tax means that your share of the costs is deducted before taxes are determined, resulting in more take-home pay for you. As a result, the IRS requires that your elections remain in effect for the entire year. You cannot drop or change coverage unless you experience a status change/qualifying event.

HELP-LINE: (866) 770-1589

The toll-free customer service help-line can provide assistance with insurance-related issues when you are unable to resolve them directly with the insurance carriers. Simply call the help-line at (866) 770-1589.

For more complicated questions or claims issues, the Heath Benefit Partners claims specialist works as your insurance advocate, researching and resolving problems quickly and effectively. If further action is required, the Heath Benefit Partners specialist will provide regular updates until the issues are resolved!

ENROLLMENT INFORMATION

Changes to Enrollment

Our benefit plans are effective October 1st through the end of September of each year. There is an annual open enrollment period each year, during which you can make new benefit elections for the following October 1st effective date. Once you make your benefit elections, you cannot change them during the year unless you experience a qualifying event as defined by the IRS. Examples include, but are not limited to the following:

- Marriage, divorce, legal separation or annulment
- Birth or adoption of child
- A qualified medical child support order
- Death of a spouse or child
- A change in your dependent's eligibility status
- Loss of coverage from another health plan
- Change in your residence or workplace (if your benefit options change)
- Loss of coverage through Medicaid or Children's Health Insurance Program (CHIP)
- Becoming eligible for a state's premium assistance program under Medicaid or CHIP

***Note:* Coverage for a new spouse or newborn child is not automatic. If you experience a change in family status, you have 31 days to update your coverage. Please contact the Benefits Department immediately to complete the appropriate elections. If you do not update your coverage within 31 days from the family status change, you must wait until the next annual open enrollment period to update your coverage.**

ANNUAL NOTICES

ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. The following is a brief summary of the annual notices:

- Medicare Part D Notice of Creditable Coverage: Plans are required to provide each covered participant and dependent a Certificate of Creditable Coverage to qualify for enrollment in Medicare Part D prescription drug coverage when qualified without a penalty/ This notice also provides a written procedure for individuals to request and receive Certificates of Creditable Coverage.
- HIPAA Notice of Privacy Practices: This notice is intended to inform employees of the privacy practices followed by Hawthorne School District group health plan. It also explains the federal privacy rights afforded to you and the members of your family as plan participants covered under a group plan.
- Women's Health and Cancer Rights Act (WHCRA): The Women's Health and Cancer Rights Act (WHCRA) contains important protections for breast cancer patients who choose breast cancer patients who choose breast reconstruction with a mastectomy. The U.S. Departments of Labor and Health sand Human Services are in charge of this act of law which applies to group health plans if the plans or coverage provide medical surgical benefits for a mastectomy.
- Newborns' and Mothers' Health Protection Act: The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time a mother and her newborn child are covered for a hospital stay following childbirth.
- Special Enrollment Rights: Plan participants are entitled to certain special enrollment rights outside of Hawthorne School District open enrollment period. This notice provides information on special enrollment periods for loss of prior coverage or the addition of a new dependent.
- Medicaid & Children's Health Insurance Program: Some states offer premium assistance programs for those who are eligible for health coverage from their employers, but are unable to afford the premiums. This notice provides information on how to determine if your state offers a premium assistance program.

***Note:* Hawthorne School District has posted all federally required annual notices on the HAWTHORNE.EASE site listed on RESOURCES AND CONTACTS page for you to download and read at your convenience.**

SELECTING THE BEST PLAN FOR YOU



We offer a variety of carriers and plans for you to choose from, both HMO and PPO.

When choosing between carriers and plans there are a number of factors to consider. Pay close attention to deductibles, co-payments, co-insurance, out-of-pocket maximums and especially the Provider Networks.

HMO plans generally offer the lowest overall cost, when you calculate both your payroll deductions and the out-of-pocket costs (deductibles, co-pays, co-insurance) when you seek any health care services.

HMO plans require you to choose a Primary Care Physician (PCP) and/or a Medical Group (PMG) from a specific network of providers (Doctors). You are required to go through your PCP to get the care you may need. The PCP will refer you for diagnostic testing or to Specialists, etc.

PPO Plans offer you the freedom to seek care directly from any Doctor of your choice, both Primary Care Physicians and Specialists. With a PPO plan you maintain control over who, when, and where you are treated. The PPO Provider Network is much larger than an HMO Network and is not restricted by Medical Group boundaries. The PPO plans will generally cost more in both payroll deductions and out of pocket costs.

ANTHEM BLUE CROSS HMO PROVIDER NETWORKS

Anthem Blue Cross offers two HMO plans that HSD employees may elect: Select HMO and Vivity HMO. Details for these plans are found on the following pages.

This page shows the participating Provider Medical Groups (PMGs) that each HMO works with. In addition to considering deductibles, co—payments, co-insurance, and out-of-pocket maximums, it is important to understand which PMGs (and thereby which doctors and medical facilities) you would have access to when choosing between these two options.

Provider Medical Groups (PMGs)	Anthem Select HMO	Anthem Vivity HMO
Affiliated Doctors of Orange County	✓	
Allied Pacific of CA IPA	✓	
Altamed Medical Group	✓	
Axminster Medical Group	✓	✓
Cedars Sinai Medical		✓
Cedars-Sinai Health		✓
Facey Medical Group	✓	✓
Greater Newport Physicians/Memorial Care	✓	
MemorialCare Medical Group	✓	✓
Optum	✓	
PIH Health Physicians Group and IPA		✓
PIH Health Systems	✓	✓
Prospect Professional IPA	✓	
Providence Care Network	✓	✓
Providence Saint John's Medical	✓	✓
St. Jude Heritage Medical Group		✓
Torrance Hospital IPA	✓	✓
UCLA Medical Group		✓

ANTHEM BLUE CROSS SELECT HMO

ANTHEM BLUE CROSS SELECT PREMIER HMO 10

With the Anthem Blue Cross Health Maintenance Organization (HMO) plan, you must choose a Primary Care Physician (PCP) or Medical Group within the Anthem Blue Cross Select HMO Network for all of your covered family members. All of your care must be directed through your PCP or Medical Group. Any specialty care you need will be coordinated through your PCP and will generally require a referral or authorization. You will receive benefits only if you use the doctors, clinics and hospitals that belong to the medical group in which you are enrolled, except in the case of an emergency. This plan uses a smaller network of the most cost effective providers to provide lower office visit co-pays and per paycheck premiums. Please note that it is your responsibility to ensure that all family members choose providers from the Anthem Blue Cross Select HMO Network.

Summary of Benefits and Coverage (SBC):

Health Insurance Issuers and group health plans are required to provide you with an easy-to-understand summary about your health plan's benefits and coverage. This regulation is designed to help you better understand and evaluate your health insurance choices. You can go on to the Ease site listed on the RESOURCES AND CONTACTS page to view the SBCs provided by our medical carriers.

PLAN FEATURES	ANTHEM BLUE CROSS SELECT HMO
Lifetime Maximum	Unlimited
Deductible (Annual)	
Individual / Family	$0/$0
Co-insurance	0%
Physician Office Visit	
Primary Care Physician	$10 Copay per visit
Specialist	$10 Copay per visit
Out of Pocket Maximum	
Individual	$1,000/ $2,500 Rx
Family	$2,000/ $3,500 Rx
Hospitalization	
Inpatient	No Charge
Outpatient	No Charge
Emergency Services	$100 Copay per visit
Lab & X-ray	No Charge/$100 Copay per test
Preventive Care	$0
Prescription	$0 Generic/$15 Generic/$30 Brand Preferred/$45 Brand Non-Preferred



FINDING A MEDICAL PROVIDER:

Go to www.anthem.com/ca/sisc or call (800) 825-5541 to find an Anthem Blue Cross Medical provider near you.

ANTHEM BLUE CROSS VIVITY HMO

ANTHEM BLUE CROSS VIVITY HMO $10: With the Anthem Blue Cross Health Maintenance Organization (HMO) plan, you must choose a Primary Care Physician (PCP) or Primary Medical Group (PMG) within the Vivity HMO Network for all of your covered family members. This plan uses a smaller network to expand member choice while keeping costs down. With a traditional HMO all of your care is typically through your PCP or PMG. Most specialty care you need will be coordinated through your PCP and will generally require a referral or authorization. You will receive benefits only if you use the doctors, clinics and hospitals that belong to the PMG in which you are enrolled, except in the case of an emergency. However, Vivity offers more access and flexibility than traditional HMO's.

Vivity's Enhanced HMO Access

Direct Access: Members can self-refer to 4 types of specialists within their PMG: Allergists, Dermatologists, ENT specialists, OB/GYN

Speedy Referral: PCP's can refer members to 16 types of specialists without Pre-Authorization from the PMG, including but not limited to: Cardiology, Dermatology, Endocrinology, General surgery, Hematology, Neurology, OB/GYN, Oncology, Orthopedic surgery, Routine lab & X-ray, Urology and more.

Physician Directed Access: Physicians can refer members to specialists within Vivity's other Medical groups.

PLAN FEATURES	ANTHEM BLUE CROSS VIVITY HMO
Lifetime Maximum	Unlimited
Deductible (Annual)	
Individual / Family	$0/$0
Co-insurance	0%
Physician Office Visit	
Primary Care Physician	$10 Copay per visit
Specialist	$10 Copay per visit
Out of Pocket Maximum	
Individual	$1,000/ $2,500 Rx
Family	$2,000/ $3,500 Rx
Hospitalization	
Inpatient	No Charge
Outpatient	No Charge
Emergency Services	$100 Copay per visit
Lab & X-ray	No Charge/ $100 per test
Preventive Care	$0
Prescription	$0 Generic/$15 Generic/$30 Brand Preferred/$45 Brand Non-Preferred

FINDING A MEDICAL PROVIDER:

Go to www.anthem.com/ca/sisc or call (844) 484-8489 to find an Anthem Blue Cross Medical provider near you.

HSD

Why Vivity?

A seamless member experience

Vivity Concierge makes transitioning health plans easier

Vivity was designed to change the way healthcare is delivered, giving you access to highly ranked doctors and hospitals that work together, sharing information and best practices.

With Vivity, if you ever want or need to see a specialist, you can ask your primary care physician (PCP) for a referral to any specialty in the network. You can even visit certain specialists without needing to wait for approval. This saves you time, puts you in control of whom you see, and helps ensure you receive the care you need.[1]

There are three ways to see a specialist:

1. Through Direct Access, you can refer yourself to dermatologists; ear, nose, and throat doctors; OB-GYNs; and allergists in your medical group without a referral from a PCP.[2]

2. **Unique to Vivity**, *Expanded Choice**lets you request to see a specialist outside your medical group. With a referral from your PCP, you can receive a consultation, ongoing treatment, and follow-up care with this specialist for your specific condition.

   This option gives you access to more than 6,000[3] top specialists from all of the partnering Vivity medical groups in Southern California.

   * Members can request a referral from the member's primary care doctor for specialty care at a partnering Vivity Medical Group. Specialty care must be deemed medically necessary, and specialists must be contracted to see Vivity patients from a partnering Medical Group or IPA.

3. With Speedy Referral, your doctor can refer you to certain types of specialists within your medical group without needing to wait for approval:

   - Allergy — allergies
   - Cardiology — heart
   - Dermatology — skin
   - Ear, nose, and throat (ENT) — head and neck
   - Endocrinology — glands
   - Gastroenterology — stomach, intestines, digestion
   - Hematology — blood
   - Neurology — brain and nerve
   - Obstetrics/gynecology — pregnancy, women's health

Need a referral?

For help finding a specialist or for other questions, visit **vivityhealth.com** or call the Vivity Concierge team at 844-4-VIVITY (844-484-8489), Monday through Friday, 8 a.m. to 8 p.m.

We can help make the referral process easier.



1. Subject to participation by member's chosen medical group.
2. Direct Access is not available in all medical groups.
3. Specialist count based on Anthem's Vivity contracted/loaded specialist network (as of 3/12/21).

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Vivity offered by Anthem

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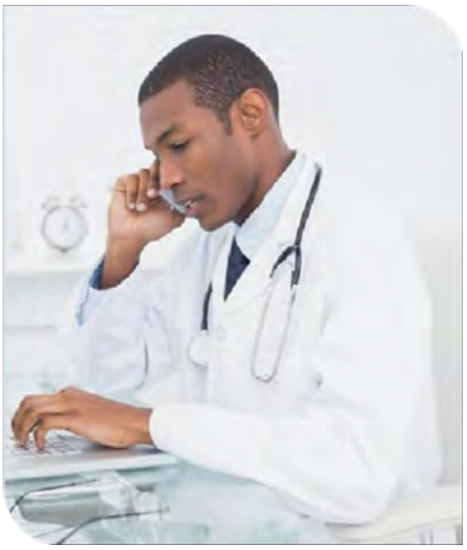
ANTHEM BLUE CROSS CUSTOM PREMIER PPO



ANTHEM BLUE CROSS PPO :

With the Anthem Blue Cross Preferred Provider Organization (PPO) plan you have the freedom to choose your doctor without using a Primary Care Physician (PCP) and you may self-refer to specialists. You may use a PPO provider whose negotiated rates provide richer levels of benefits with claim forms filed by the providers. You may also obtain services using a non-network provider; however, you will incur much higher out-of-pocket expenses and you may be responsible for filing claims. Non-network benefits will be based on a limited fee schedule, determined by Anthem Blue Cross.

PLAN FEATURES	ANTHEM BLUE CROSS Options PPO 90/70	
	In-Network	**Out-of-Network**
Lifetime Maximum	Unlimited	Unlimited
Deductible (Annual)		
Individual / Family	$250/$500	$250/$500
Co-insurance	10%	30%
Physician Office Visit		
Primary Care Physician	$0 for 1st 3 visits, then $20 per visit	30% Co-Insurance
Specialist	$20 Copay per visit	30% Co-Insurance
Out of Pocket Maximum		
Individual	$1,000/ $2,500 Rx	$3,000/ $2,500 Rx
Family	$2,000/ $3,500 Rx	$6,000/ $3,500 Rx
Hospitalization		
Inpatient	10% Co-Insurance	$250 per admit + 30% Co-Insurance (Up to $1,500 per day)
Outpatient	10% Co-Insurance	30% Co-Insurance (Up to $350 per admit)
Emergency Services	$50 Copay then 10%	Same as In-Network
Lab & X-ray	10% Co-Insurance	30% Co-Insurance
Preventive Care	0%	Not Covered
Prescription	$0 Generic/$5 Generic/$15 Brand Preferred/ $30 Brand Non-Preferred	Member must pay the entire cost up front and apply for reimbursement

FINDING A MEDICAL PROVIDER:

Go to www.anthem.com/ca/sisc or call (800) 825-5541 to find an Anthem Blue Cross Medical provider near you.

MDLIVE

SISC
Self-Insured Schools of California
Schools Helping Schools

Need a doctor? No long wait. $10 copay. Always open.



With MDLIVE, you can visit with a doctor 24/7 from your home, office or on-the-go.

Welcome to MDLIVE! Your anytime, anywhere doctor's office.

Visit a doctor by phone, secure video, or MDLIVE App. Pediatricians are available 24/7, and family members are also eligible. Behavioral health and psychiatric visits are available from the convenience of your own home.

Per IRS guidelines, HSA members are responsible for the full cost of the visit until their deductible is met.

U.S. board-certified doctors with an average of 15 years of experience.

Consultations are convenient, private and secure.

Prescriptions can be sent to your nearest pharmacy, if medically necessary.

Your COPAY is $10

Your copay is $10 for all visits

HSA Members must meet annual plan deductible before acessing $10 visits.

We treat over 50 routine medical conditions including:

- Acne
- Allergies
- Cold / Flu
- Constipation
- Cough
- Diarrhea
- Ear Problems
- Fever
- Headache
- Insect Bites
- Nausea / Vomiting
- Pink Eye
- Rash
- Respiratory Problems
- Sore Throats
- Urinary Problems / UTI
- Vaginitis
- And More

Download the app.
Join for free. Visit a doctor.

MDLIVE.com/sisc
1-800-657-6169

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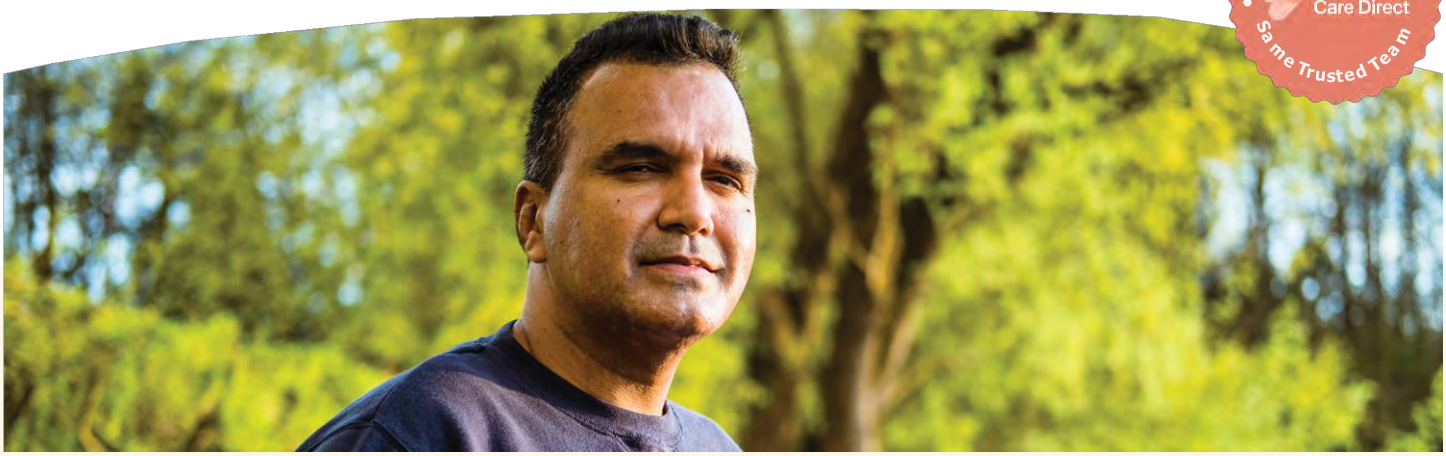
LANTERN

SISC
Self-Insured Schools of California
Schools Helping Schools

Formerly Known As Cancer Care Direct Same Trusted Team



If You Ever Need Cancer Care, **We're** Here to Light Your Path

Lantern provides personalized guidance and support throughout the cancer journey. Our expert support team will help you or a loved one navigate the path ahead, connecting you with the best providers while coordinating care along the way.

An Experience with You at the Center

We're here to answer your questions and ensure that you understand the path ahead and that you have confidence in your team and treatment plan. We put the patient and their loved ones at the center of care, as we believe that a better more compassionate experience leads to better outcomes.

Call Us to Learn More at (855) 961-4533

Email: guide@lanterncare.com

Visit Lantern Today.

You can chat with nurses, track appointments and symptoms, and more.

The Lantern Difference

1. **Guided Support**
   Your personal Oncology Nurse Navigator-led team will be with you every step of the journey, coordinating appointments, explaining treatment information, and answering questions.
2. **Accessing Excellent Care**
   We connect you with the best in-network community oncology clinics, hospitals, and National Cancer Institutes for high-quality care as close to home as possible.
3. **Expert Review & Advice**
   Our team will assist in coordinating the expert review of members' diagnoses and treatment plans, recommending second opinions and referrals as needed.

"Because my Oncology Nurse Navigator was able to get appointments within two weeks instead of waiting months and months, I was quickly enrolled into a treatment plan that has me on a path to recovery."

— Craig, Cancer Survivor and Lantern Member

LANTERN

SISC
Self-Insured Schools of California
Schools Helping Schools

Formerly known as Cancer Care Direct. Same Trusted Team

Frequently Asked Questions

Who can benefit from Lantern?

Lantern can help if you or a member of your family has been diagnosed with cancer. It's included as part of your medical benefits through <Client> at no extra cost to you.

I was diagnosed with cancer. What should I do to get started with Lantern?

Reach out to us as soon as you can—our team is only a phone call away and ready to help. Call Lantern at (855) 204-3923. We have Oncology Nurse Navigators and Care Guides available to help Monday through Friday, between 8 a.m. and 5 p.m. CT. You can also email us at guide@lanterncare.com.

I'm already getting cancer treatment. Can Lantern still help?

Yes. We provide guidance and support to our members at any point in their cancer journey, from initial diagnosis to remission. Call our team to see how we can help you.

I've already completed treatment, and I'm in remission. Can you still help me?

Yes. We're here to help you through survivorship. Our team can help you with continued screenings, guidelines, managing treatment late effects and more. We're also here to help you transition back into your daily life after cancer.

What will it cost me to use Lantern?

Lantern doesn't cost you anything. It's included as part of your <Client> medical benefits. You won't be billed for using Lantern.

Can Lantern help get treatment approved for me?

Yes. As your advocates, we work with your doctors and insurance to help get approvals for your treatment.

What do the Lantern Oncology Nurse Navigators and Care Guides do?

Our Oncology Nurse Navigators are experts in the field. They provide timely clinical guidance, coordinate care, facilitate expert advisory support and offer social and emotional support when you need it. Our Care Guides work with our nurses to coordinate any travel and appointments, request medical records and get answers to your questions. They help you handle the details, so you can focus on your health.

Will Lantern help cover the cost of my treatment or surgery?

No. Lantern does not cover the cost of surgeries or treatments. That will still be provided through your medical insurance. Lantern may be able to help with travel costs to and from appointments for your cancer diagnosis. Your team can also connect you with resources in your community that can provide financial help.

I like my oncologist. Do I have to switch doctors to use Lantern?

No. You can stay with your current oncologist and still get help from Lantern. But if you need to find an oncologist or want a second opinion, we can assist with finding a doctor and scheduling your appointments.

What happens if my insurance changes?

If your new insurance doesn't include Lantern as a benefit, our team will work with you to find resources and support in your community as you transition onto your new insurance plan. Our goal is to help you have a seamless transition if it's needed.

If your new insurance includes Lantern as a benefit, you can continue working with your team. If your new insurance doesn't provide Lantern, talk to your human resources department about adding it to your coverage.

Call us to learn more at:

(855) 961-4533

Visit Lantern Today.

You can chat with nurses, track appointments and symptoms, and more.

In the event of a medical emergency, call 911 or visit your nearest emergency room.

Anthem BlueCross | SISC | Hinge Health

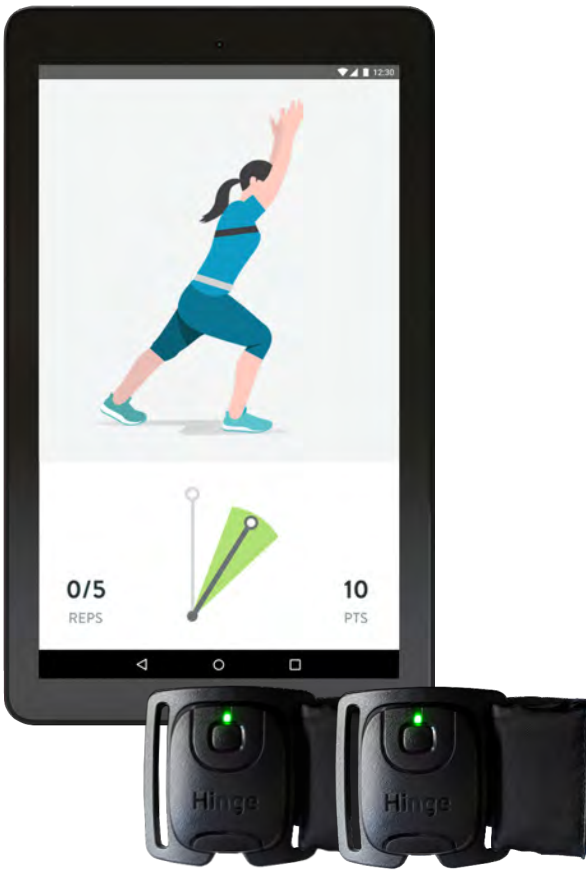


Conquer back or knee pain without drugs or surgery

Members on the SISC Anthem medical plan get free access to Hinge Health's innovative digital programs for back or knee pain.

Over 15,000 have completed the Hinge Health program. Here's just one testimonial:

"I considered back surgery,but wanted to try everything else first. Hinge Health gave me the tools I need to succeed without surgery. I now know that surgery can be avoided."



Questions? Call (855) 902-2777

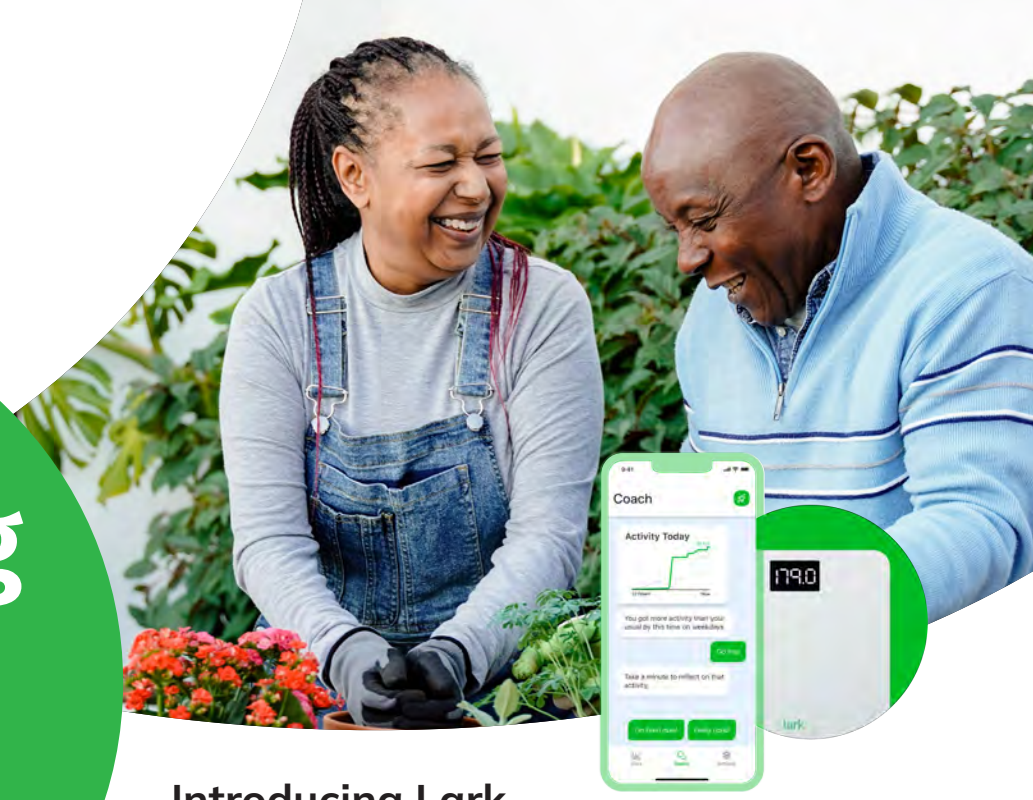
Eligibility: Must be 18+ and enrolled in a SISC/Anthem PPO medical plan.

To learn more and apply, visit:

HINGEHEALTH.COM/SISC

lark

Preventing diabetes just got easier



Introducing Lark Digital Health Coaching

People with prediabetes have higher than normal blood sugar which can substantially increase the risk of developing type 2 diabetes. People often don't even know they have prediabetes, because it can occur with no symptoms. The good news is that there are steps you can take now to decrease your risk.

Your employer has teamed up with Lark to bring you access to the tools you need to take those steps and prevent type 2 diabetes. Available 24/7 on your smartphone, the Lark Diabetes Prevention Program is included at no extra cost as a benefit of your health plan. If you qualify, you'll also get a digital scale with the opportunity to earn a Fitbit®.

Together we can help you:

- Create healthy eating habits
- Reach or maintain a healthy weight
- Make time for physical activity
- Manage stress levels
- Improve sleep quality

Get started with a quick eligibility survey

Scan this QR code with your smartphone camera to get started.

Or visit **enroll.lark.com/anthem**

Eligibility requirements for the Lark Diabetes Prevention Program include qualifying as prediabetic according to a survey designed by the Centers for Disease Control and membership in a participating health plan. You may be eligible to earn health-related devices such as a scale or Fitbit® at no cost to you. The ability to earn health-related devices may vary by health plan and may contain minimum program engagement requirements, such as weighing in, completing missions with your digital coach, and logging activity or meals. Eligibility determinations are made by Lark at its sole discretion.

Fitbit is a registered trademark of Fitbit Inc.

SleepCharge®
BY NOX HEALTH

Welcome to SleepCharge

Wake up to a brighter world!



All Health Plan Members Are Eligible

Get your personalized sleep report

Complete the Sleep Checkup to get your personalized sleep report, which includes an analysis of your Duration, Timing & Quality (DTQ). Use your report to lay the foundation for sleep improvement.

Access the Sleep Life Learning Center

Explore our virtual, self-guided library of sleep education and guided bedtime mindfulness, to help you achieve a healthier sleep lifestyle.

Receive sleep health support

From sleep coaching to treatment for sleep disorders such as insomnia, sleep apnea and restless legs syndrome, SleepCharge provides proactive and virtual sleep care tailored to your needs.

To get started, take the Sleep Checkup by visiting sleepcharge.com/ascip

All confidential medical information obtained through SleepCharge will be maintained in accordance with federal HIPAA requirements.

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877-615-7257 | sleep@sleepcharge.com

YOUR GUIDE TO

The SleepCharge Journey

1

The Sleep Checkup

Get a quick online assessment of your sleep.

2

Evaluation & History

Tell us more about your medical history and sleep concerns.

3

Virtual Consultation

Discuss your sleep concerns with a physician through a telemedicine appointment.

4

Testing & Diagnostics

Complete any test needed for an accurate medical diagnosis.

5

Continuous Virtual Care

Follow your personalized treatment plan with support at every step.

Currently being treated for a sleep disorder?

Now is the time to move your care and experience the SleepCharge difference. Call 877-615-7257, option 2.

Get started with the Sleep Checkup at sleepcharge.com/ascip

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877-615-7257 | sleep@sleepcharge.com



Live life to the fullest – without paying full price

Save money with discounts at anthem.com/ca

Saving money is good. Saving money on things that are good for you — that's even better. With SpecialOffers, you can get discounts on products and services that help promote better health and well-being.* It's just one of the perks of being an Anthem member. Check out how much you can save:

Vision, hearing and dental

Glasses.com™ and 1-800-CONTACTS® — Get the latest brand-name frames for just a fraction of the cost at typical retailers — every day. Plus, you get an additional $20 off orders of $100 or more, free shipping and free returns.

EyeMed — Get 30% off a new pair of glasses, 20% off non-prescription sunglasses and 20% off all eyewear accessories.

Premier LASIK — Save $800 on LASIK when you choose any 'featured' Premier LASIK Network provider. Save 15% with all other in-network providers.

TruVision — Save up to 40% on LASIK eye surgery at more than 1,000 locations (over 6.5 million procedures performed in the network).

Nations Hearing — Get hearing screenings and in-home service at no additional cost. All hearing aids start at $599 each, powered by the Beltone network.

Hearing Care Solutions — Digital instruments start at $500. Plus, get a free hearing exam. Hearing Care Solutions has 3,100 locations and eight manufacturers, and offers a three-year warranty, two years of batteries and unlimited visits for one year.

Amplifon — Get 25% off, plus an extra $50 off one hearing aid; $125 off two.

ProClear™ Aligners — Get $1,200 off a set of custom aligners. Improving your smile shouldn't cost a fortune. Now you can get a beautiful, professional smile in the comfort of your own home — all at a 50% savings. No metal braces; no time-consuming dentist visits; no hidden fees. Order now and get a free whitening kit, along with your great-looking smile.

Anthem

Check out more SpecialOffers on the other side.

SpecialOffers on anthem.com/ca

Fitness and health

Active&Fit Direct™ — Active&Fit Direct allows you to choose from more than 9,000 participating fitness centers nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes). Offered through American Specialty Health Fitness, Inc.

FitBit — Get fit your way with Fitbit trackers and smartwatches that fit with your lifestyle, budget and goals. Save up to 22% on select Fitbit devices.

Garmin — Get 25% off select Garmin wellness devices.

Jenny Craig — Take advantage of a free, three-month program (food not included) plus $120 in food savings (purchase required), or save 50% off premium programs (food cost separate).

ChooseHealthy — Get discounts on acupuncture, chiropractic, massage and fitness clubs.

Global Fit — Get discounts on gym memberships, fitness equipment, coaching and more.

Family and home

23andMe — Get $40 off each Health + Ancestry kit. Your DNA says a lot about you. Save 20% on a 23andMe kit and learn about your wellness, ancestry and more.

Safe Beginnings® — Babyproof your home while saving 15% on everything from safety gates to outlet covers.

Nationwide Pet Insurance — Receive an automatic 5% discount when you enroll through your company or organization. Save up to 15% when you enroll multiple pets.

ASPCA Pet Insurance — Get 5% off pet insurance. You can choose from three levels of care, including flexible deductibles and custom reimbursements.

WINFertility® — Save up to 40% on infertility treatment. WINFertility helps make quality treatment affordable.

LifeMart® — Get great deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services and yoga classes, sports gear and vision care.

Medicine and treatment

SelfHelpWorks — Choose one of the online Living programs and save 15% on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep or face an alcohol problem.

Brevena — Enjoy a 41% discount on BREVENA® skin care creams and balms for smooth, rejuvenated skin from face to foot.

Puritan's Pride — Choose from a large selection of discounted vitamins, minerals and supplements from Puritan's Pride.

Allergy Control Products — Save 20% on select doctor-recommended products such as allergy friendly bedding, air purifiers and filters, asthma products and more. Plus enjoy free shipping on all orders over $79 when shipping ground within the contiguous U.S.

National Allergy® supply — Save 20% on select National Allergy® Doctor Recommended Products.

- Allergy bedding
- Air purifiers and filters
- Home allergy products
- Personal care
- Humidifiers and dehumidifiers
- Vacuums and steam cleaners

To find the discounts that are available to you, log in to **anthem.com/ca** and select **Discounts**.

* All discounts are subject to change without notice.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Your Employee Assistance Program

SISC

Your Employee Assistance Program (EAP) is here to help you and your household through difficult times. The following resources are private, confidential, and available to you 24/7 at no extra cost.[1]

Counseling and mental health

- Get six free visits for in-person or virtual counseling per person in your household, per issue each year.[2]

Work-life resources

- Find information on career, parenting, and balancing work and family.
- Find high-quality child, elder, and pet care.
- Receive special discounts on a range of products and services, including food, travel, and clothing.

Identity theft support

- Register to get help with identity monitoring and theft resolution to minimize or recover from the effects of identity theft.

Self-improvement resources

- Log in to take self-assessments, access the Guidance to Care tool, and get a list of EAP resources specific to your needs.
- Use Emotional Well-being Resources to connect with one-on-one coaching and self-help digital tools.

Legal and financial resources

- Book a no-cost consultation and receive a discounted rate from participating local attorneys on continued legal services.[3]
- Explore an online library of legal resources, forms, and essential documents.
- Have unlimited phone consults with a financial professional and access online financial calculators and budgeting tools.

24/7 crisis support

- Get in-the-moment support when experiencing a personal crisis.
- Find help with navigating resources and getting support if you're impacted by a tragedy or natural disaster.

Get the help you need, 24/7

- Visit **anthemEAP.com/sisc.** You can also scan this QR code with your phone's camera.
- Call your EAP at **800-999-7222** for help with questions.

Anthem

SISC
Self-Insured Schools of California
Schools Helping Schools

1 In accordance with federal and state law, and professional ethical standards.

2 Appointments are subject to availability of a therapist. Online counseling is not appropriate for all kinds of problems. If you are in a crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 988 (National Suicide Prevention Lifeline) and ask for help. If your issue is an emergency, call 911 or go to the nearest emergency room.

3 Excludes business, benefits, or employment issues. The free half-hour consultations apply per legal issue, per year. You are eligible for a new consultation for each new issue yearly.

This document is for general information purposes. Check with your employer for specific information on services available to you.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

EAP products are offered by Anthem Insurance Companies, Inc.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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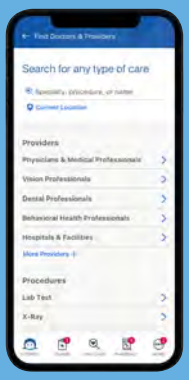
Connect with the care that's right for you

The Find Care tool helps you search for doctors/dentists and compare costs

Choosing a provider you trust is important — and choosing one in your plan's network can help keep your costs down. Finding high-quality, cost-effective care is simple when you use the Find Care tool on the Sydney Health mobile app or **anthem.com/ca.**

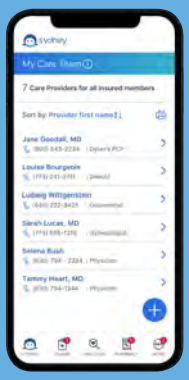
How to use Find Care

The Find Care tool brings together details about doctors, dentists, hospitals, labs, and healthcare facilities in your plan's network. You can easily compare information such as costs, location, and office hours. You can:



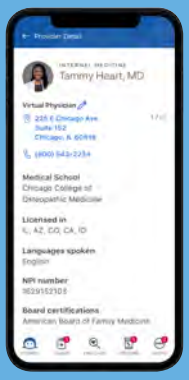
1

Search for providers and facilities in your plan's network by name, specialty, or procedure.



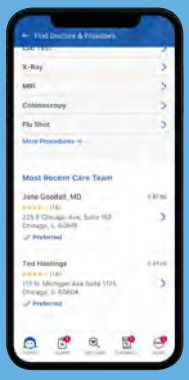
2

Customize the list of providers you see in your search based on factors that are most important to you, such as languages spoken, affiliated hospitals, and location.



3

Review details about doctors/ dentists such as their specialties, gender, educational background, and contact information.



4

Choose a doctor/ dentist from the list to review their patient ratings and compare costs for services.

Choose with confidence

You can start using **Find Care** by downloading the Sydney Health app to your mobile device or logging in to **anthem.com/ca.** Select **Find Care** and the Find Care tool will guide you through the steps.

We're ready to help you

The Find Care tool empowers you to take control of your healthcare by helping you connect with high-quality care options. If you have questions, you can reach us using the interactive chat feature on the Sydney Health app or through the Message Center on **anthem.com/ca.**

Download Sydney Health today to find a provider that's right for you

Use your smartphone camera to scan this QR code.

Anthem

SISC
Self-Insured Schools of California
Schools Helping Schools

Sydney Health is offered through an arrangement with CareMarket, Inc. Sydney and Sydney Health are trademarks of CareMarket, Inc.
Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
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KAISER PERMANENTE

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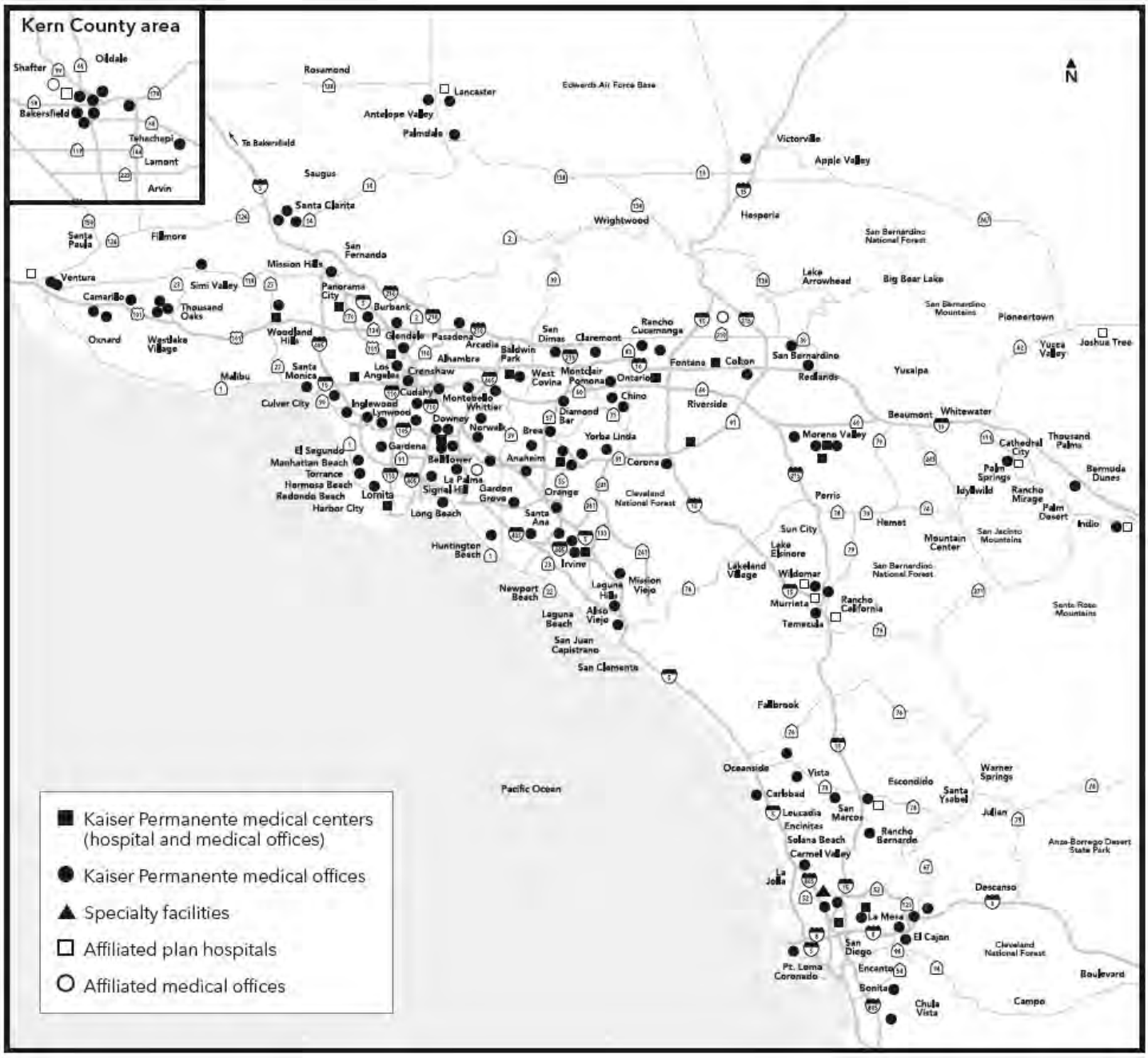
SOUTHERN CALIFORNIA LOCATIONS



KAISER PERMANENTE®

LA COUNTY LOCATIONS

City	Facility	Address
Baldwin Park	■ Baldwin Park Medical Center	1011 Baldwin Park Blvd.
Bellflower	• Bellflower Medical Offices	9400 E. Rosecrans Ave.
	• Rosecrans Medical Offices	9333 E. Rosecrans Ave.
Carson	• Carson Medical Offices	18600 S. Figueroa St.
Cerritos	• Cerritos Medical Offices	10820 E. 183rd St.
City Of Industry	• Crossroads Medical Offices	12801 Crossroads Pkwy. S.
Claremont	• Indian Hill Medical Offices	250 W. San Jose St.
Cudahy	• Cudahy Medical Offices	7825 Atlantic Ave.
Culver City	• Playa Vista Medical Offices	5620 Mesmer Ave.
Diamond Bar	• Diamond Bar Medical Offices	1336 Bridgegate Dr.
Downey	■ Downey Medical Center	9333 E. Imperial Hwy.
	• Garden Medical Offices	9353 E. Imperial Hwy.
	• Orchard Medical Offices	9449 E. Imperial Hwy.
Gardena	• Gardena Medical Offices	15446 S. Western Ave.
Glendale	• Glendale Medical Offices	444 W. Glenoaks Blvd.
	• Glendale Orange Street Medical Offices	501 N. Orange St.
Harbor City	■ South Bay Medical Center	25825 S. Vermont Ave.
Inglewood	• Inglewood Medical Offices	110 N. La Brea Ave.
Lancaster	□ Antelope Valley Hospital — Emergency services*	1600 W. Avenue J
	• Antelope Valley Medical Offices	615 W. Avenue L
Lancaster	• Lancaster Medical Offices	43112 N. 15th St. W.
	• Women's Health Office (Ob-Gyn)	44105 15th St. W.
Lomita	• Lomita Medical Offices	2081 Palos Verdes Dr. North
Long Beach	• Long Beach Medical Offices	3900 E. Pacific Coast Hwy.
Los Angeles	• Baldwin Hills–Crenshaw Medical Offices	3780 West MLK Blvd.
	• Culver Marina Medical Offices	12001 W. Washington Blvd.

■ Kaiser Permanente medical centers (hospital and medical offices)

● Kaiser Permanente medical offices
▲ Specialty facilities

□ Affiliated plan hospitals
◯ Affiliated medical offices

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LA COUNTY LOCATIONS

City	Facility	Address
Los Angeles	● Downtown Los Angeles Hope Street Medical	333 S. Hope St.
	● East Los Angeles Medical Offices	5119 E. Pomona Blvd.
	■ Los Angeles Medical Center	4867 W. Sunset Blvd.
	● South Los Angeles Medical Offices	1550 W. Manchester Ave.
	■ West Los Angeles Medical Center	6041 Cadillac Ave.
Lynwood	● Lynwood Medical Offices	3830 Martin Luther King Jr. Blvd.
Manhattan Beach	● Manhattan Beach Medical Offices	400 S. Sepulveda Blvd.
Mission Hills	● Mission Hills Medical Offices	11001 Sepulveda Blvd.
Montebello	● Montebello Medical Offices	1550 Town Center Dr.
North Hollywood	● North Hollywood Medical Offices	5250 Lankershim Blvd.
Norwalk	● Norwalk Medical Offices	12501 E. Imperial Hwy.
Palmdale	● Palmdale Medical Offices	4502 E. Avenue S
Panorama City	■ Panorama City Medical Center	13651 Willard St.
Pasadena	● Pasadena Medical Offices	3280 E. Foothill Blvd.
San Dimas	● San Dimas Medical Offices	1255 W. Arrow Hwy.
Santa Clarita	● Canyon Country Medical Offices	26415 Carl Boyer Dr.
	● Santa Clarita Medical Offices	27107 Tourney Rd.
	● Santa Clarita Medical Offices 2	36877 Tourney Rd.
Santa Monica	● Santa Monica Medical Offices	1450 10th St., 2nd Floor
Signal Hill	● Signal Hill Medical Offices	845 E. Willow St.
Torrance	● Torrance Medical Offices	20790 Madrona Ave.
West Covina	● West Covina Medical Offices	1249 S. Sunset Ave.
Whittier	● Whittier Medical Offices	12470 E. Whittier Blvd.
Woodland Hills	● Erwin Street Medical Offices	21263 Erwin St.
	■ Woodland Hills Medical Center	5601 De Soto Ave.

■ Kaiser Permanente medical centers (hospital and medical offices)

● Kaiser Permanente medical offices
▲ Specialty facilities

□ Affiliated plan hospitals
◯ Affiliated medical offices

KAISER PERMANENTE®

KAISER PERMANENTE HMO



KAISER PERMANENTE HMO:

With the Kaiser Permanente Health Maintenance Organization (HMO) plan, you must seek all services within the Kaiser Permanente HMO Network for all of your covered family members. All of your care must be directed through Kaiser Permanente. Any specialty care you need will be coordinated through Kaiser Permanente and will generally require a referral or authorization. You will receive benefits only if you use the doctors, clinics, and hospitals that belong to Kaiser Permanente, except in the case of an emergency.

PLAN FEATURES	KAISER PERMANENTE HMO $10 COPAY PLAN
Lifetime Maximum	Unlimited
Deductible (Annual)	
Individual / Family	$0/$0
Co-insurance	$0
Physician Office Visit	
Primary Care Physician	$10 Copay per visit
Specialist	$10 Copay per visit
Out of Pocket Maximum	
Individual	$1,500
Family	$3,000
Hospitalization	
Inpatient	No Charge
Outpatient	$10 Copay per Procedure
Emergency Services	$100 Copay per visit
Lab & X-ray	No Charge
Preventive Care	$0
Prescription	$5 Generic, $10 Brand

FINDING A MEDICAL PROVIDER:

Go to www.kp.org or call (800) 464-4000 to find an Kaiser Permanente Medical provider near you.



KAISER PERMANENTE®

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YOUR CARE, YOUR WAY

Connect to care anytime, anywhere

Get the care you need the way you want it. No matter which option you choose, your providers can see your health history, update your medical record, and give you personalized care that fits your life.

Choose where, when, and how you get care

To make an appointment, call us at **1-833-KP4CARE (1-833-574-2273)** or **711** (TTY), Monday through Friday, 7 a.m. to 7 p.m. You can also schedule some appointments online at **kp.org/getcare** or with the Kaiser Permanente app.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at **1-833-KP4CARE (1-833-574-2273)** or **711 (TTY)**.

In-person visit

Same-day appointments are often available. Sign on to **kp.org** anytime, or call us to schedule a visit.

Email

Message your doctor's office with nonurgent questions anytime. Sign on to **kp.org** or use our mobile app.[2,3]

Phone appointment

Save yourself a trip to the doctor's office for minor conditions by scheduling a call with a doctor.[2,3]

Video visit

Meet face-to-face online with a doctor on your computer, smartphone, or tablet for minor conditions or follow-up care.[2, 3, 4]

E-visit

Get quick online care for minor health problems. Fill out a short questionnaire about your symptoms, and a clinician will get back to you with a care plan—usually within 2 hours.

Need care now? Know before you go.

URGENT CARE

An urgent care need is one that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition. This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms, and frequent urination or a burning sensation when urinating. Visit kp.org/getcare to find the urgent care location nearest you.

EMERGENCY CARE

Emergency care is for medical or psychiatric condition, including severe pain, that requires immediate medical attention to prevent serious jeopardy to your health.[1] Examples include chest pain or pressure, severe shortness of breath, and decrease in or loss of consciousness. If you think you have a medical or psychiatric emergency, call 911 or go to the nearest hospital. Not sure where to go? We're here 24/7 to guide you. Call us at 1-833-KP4CARE (1-833-574-2273) or 711 (TTY).

[1]If you reasonable believe you have an emergency medical condition, call **911** or go to the nearest emergency department. An emergency medical condition is a medical or psychiatric condition that requires immediate medical attention to prevent serious jeopardy to your health. For the complete definition of an emergency medical condition, please refer to your *Evidence of Coverage*.
[2]These features are available when you receive care at Kaiser Permanente facilities.
[3]You must be 18 years or older to schedule.
[4]Check with your doctor's office to find out if video visits are available to you.



Pharmacy made easier

Save time with convenient new features

Get most medications delivered to your door

Delivery within 3 to 5 days at no extra cost — or choose same-day or next-day delivery for an additional fee.*

Opt in for reminders and updates

We'll let you know when it's time for a refill — and when your order is out for delivery or ready for pickup.

Enjoy convenient pickup options

Pick up new prescriptions on the same day at no extra cost. Plus, use your phone to pay for prescriptions quickly and safely.

Get started now

at **kp.org/pharmacy** or on the Kaiser Permanente app.

* Some exclusions apply. For more information, contact the pharmacy. Same-day and next-day prescription delivery services may be available for an additional fee. These services are not covered under your health plan benefits and may be limited to specific prescription drugs, pharmacies, and delivery addresses. Order cutoff times and delivery days may vary by pharmacy location. Kaiser Permanente is not responsible for delivery delays by mail carriers. Kaiser Permanente may discontinue same-day and next-day prescription delivery services at any time without notice and other restrictions may apply. Medi-Cal and Medicaid beneficiaries should ask your local pharmacy for more information.

KAISER PERMANENTE®

CLINIC

CARE PROVIDED BY KAISER PERMANENTE®

kptargetclinic.org

MAKE FIRST-RATE CARE YOUR NEXT STOP

Looking for an easy care option close to where you work or live? Stop by your local Target Clinic. Our highly skilled Kaiser Permanente care teams are ready to treat your health needs.



More than 85 services available, including:

- Flu shots
- Wellness exams for babies, children, and adults
- School physicals
- Hearing and vision tests
- Care for minor illness or injuries

Not a Kaiser Permanente member?
Not a problem. Everyone is welcome.

kp.org/scal/targetclinic

KAISER PERMANENTE®

HEALTHY LIFESTYLE PROGRAMS

Take a total health assessment with Succeed™

Our free online total health assessment tool helps you examine the many factors currently affecting your health and prioritize the lifestyle changes it recommends. Save your summary of results in your electronic medical record so you can discuss next steps with your Kaiser Permanente health care team. Available in both English and Spanish.

Lose weight with Balance™

This comprehensive weight loss system is designed by knowledgeable health professionals. Helpful tools and a personalized plan will show you how to coordinate three key areas—mind, food, body—to help you lose weight and keep it off. Available in both English and Spanish.

Quit smoking with Breathe™

This award-winning program can help you quit smoking for good. Create a personalized quitting plan with proven strategies for decreasing your dependency and dealing with cravings. Available in both English and Spanish.

Manage diabetes with Care™ for Diabetes

Manage this complex, chronic disease with a program that's designed around your personal needs so you can lead a healthier, more satisfying life. Available in English only.

Manage chronic conditions with Care™ for Your Health

This customized plan helps you handle medications and treatments and face daily challenges—all on a schedule that's convenient for you. Available in English only.

Manage pain with Care™ for Pain

Everyone's pain and tolerance levels are different. A personalized pain management plan can help you enjoy life to the fullest while dealing effectively with your chronic pain. Available in English only.

Eat healthy with Nourish™

You are what you eat. Create a nutrition plan that's custom-made for your lifestyle, with personalized strategies for making smart, satisfying food choices that can improve your health and well-being. Available in both English and Spanish.

Manage depression with Overcoming™ Depression

Depression can leave you feeling downcast, extremely tired, or even filled with anxiety, for weeks or months at a time. Learn to lead a happier, fuller life by finding ways to manage your symptoms. Available in English only.

Get a good night's sleep with Overcoming™ Insomnia

Changing the way you think about sleep can help you get some much-needed shut-eye so you wake up refreshed and ready to take on the day. Available in English Only.

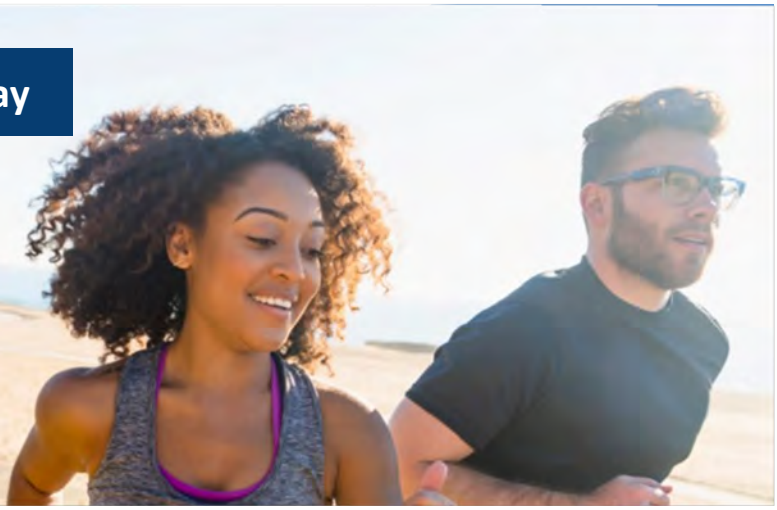
Overcome stress with Relax™

Examine your individual sources and symptoms of stress and develop a customized stress management plan that will help you start living a longer, healthier, more relaxed life. Available in both English and Spanish.

To pick the program you want, sign on to kp.org/healthylifestyles.

Connect with a wellness coach today

You can do it. Your coach can help.



Your personalized path to better health

Working with a wellness coach can help you to reach your goals with a personalized action plan and one-on-one support. You'll work with the same coach for your entire program, so they can get to know you and help you discover what works for you.

Having someone in your corner can make all the difference

Your coach is there to keep you motivated, track your progress, and celebrate your successes. Wellness coaching can help you:

- Achieve a healthy weight
- Stop using tobacco
- Become more active
- Reduce stress
- Eat healthier

Get started today

Call **1-866-862-4295**, Monday through Friday, from 7 a.m. to 7 p.m. Pacific time to make an appointment. Coaching is offered in English and Spanish,[1] no referral is needed, and there's no charge for Kaiser Permanente members.[2]

Wellness coaching works

"My coach, Kimberli, cares about me — she remembers my circumstances and is interested in what's happening in my life — and she's there to help."

— Terri, lost 40 pounds and kept it off

"On a scale of 1 to 10, my stress level was a 10. Today I am happier and much more confident in identifying specific steps to reduce stress."

— Claudia, learned how to keep stress in check

1 Spanish-speaking wellness coaches are not available in Hawaii.
2 Information about the coaching services you receive will be included in your electronic health record and accessible by your Kaiser Permanente care team (not available for Kaiser Foundation Health Plan of Washington members at this time).
Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 601 Union St., Suite 3100, Seattle, WA 98101

kp.org/coaching

KAISER PERMANENTE®



Feeling overwhelmed?

Tap into the power of self-care.

Adult members can download 2 popular apps at kp.org/selfcareapps

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

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

Calm

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

myStrength

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

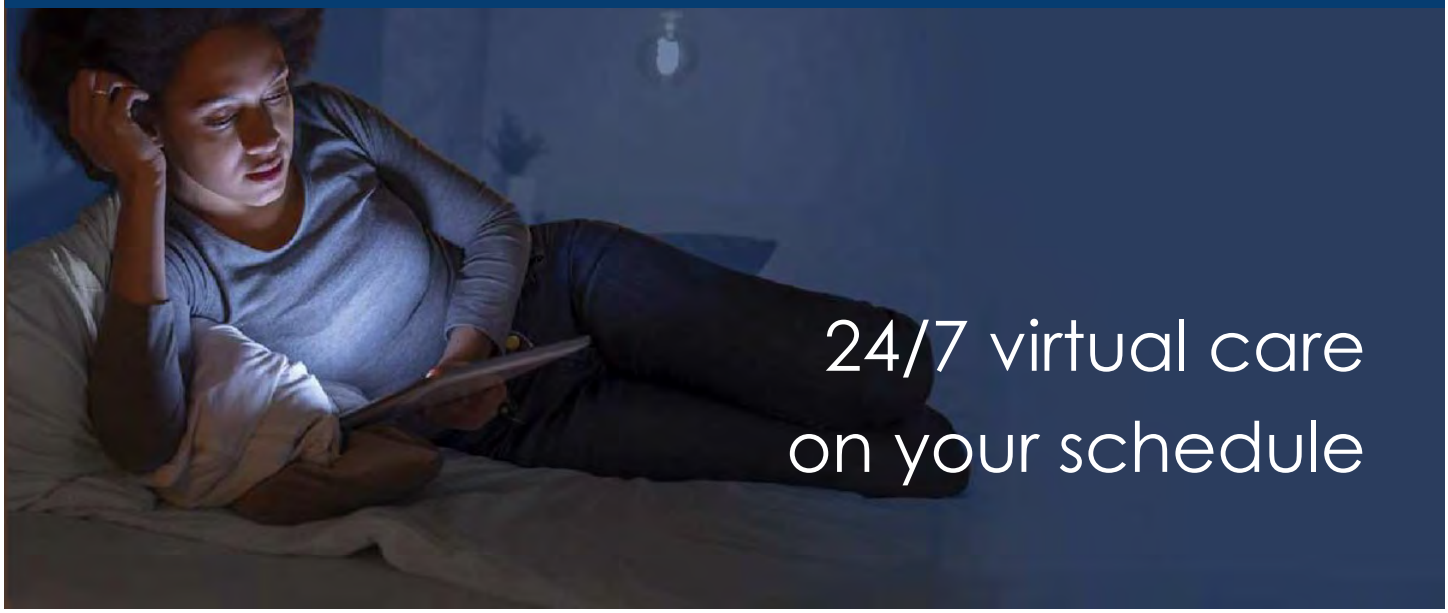
myStrength® is a trademark of Livongo Health, Inc., a wholly owned subsidiary of Teladoc Health, Inc.

Get the apps at **kp.org/selfcareapps**.

The services described above are not covered under your health plan benefits and are not subject to the terms set forth in your Evidence of Coverage or other plan documents. These services may be discontinued at any time without notice.
Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii
Kaiser Foundation Health Plan of Colorado• Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 601 Union St., Suite 3100, Seattle, WA 98101

KAISER PERMANENTE®

A BETTER WAY TO TAKE CARE OF BUSINESS



Fast, personalized support around the clock

Health problems can get in the way of a good day's work. Getting care shouldn't. That's why Kaiser Permanente makes it easy for your team to quickly connect with a clinician, from the lunchroom to the living room.

Daytime, nighttime, anytime.
That's care at the speed of your workforce.



24/7 virtual care
when your employees need it

No cost
to members on most plans

High-quality support
from clinicians who coordinate your employees' care



Connected care at every step

When your employees get 24/7 care by phone or video, their visit is tracked in their electronic health record. This helps make it easier for our clinicians to continue making informed care decisions and streamline your employees' follow-up care- no matter how they choose to see us.

Contact your Kaiser Permanente representative to learn more.

kp.org/choosebetter

KAISER PERMANENTE®

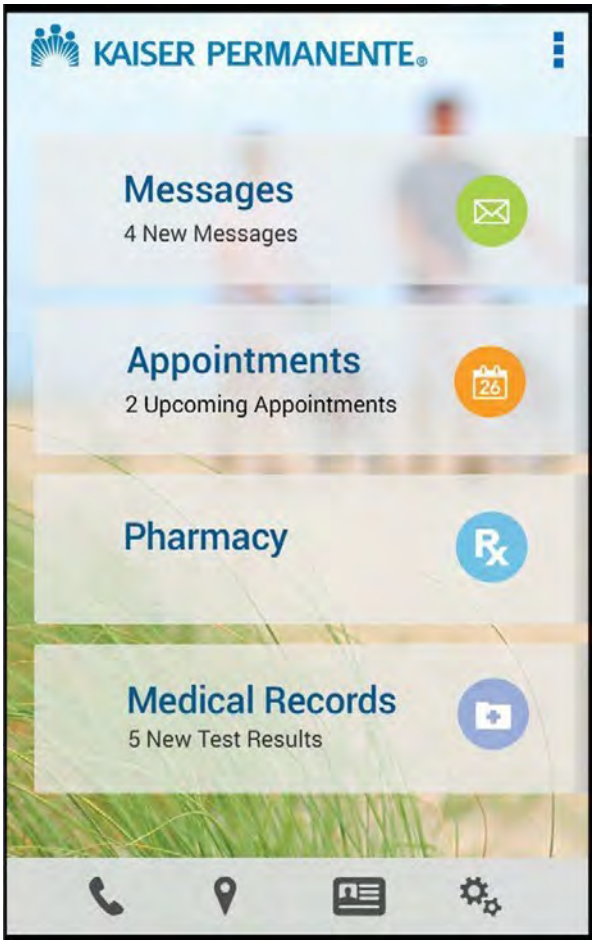
GOOD HEALTH IS IN YOUR HANDS

Use the convenient features of My Health Manager right from your smartphone or other mobile device.

- Email your doctor's office
- View most test results
- Schedule or cancel routine appointments
- Refill most prescriptions
- View past visits

Just download the Kaiser Permanente app at no cost from your preferred app site.

GET IT ON Google Play Download on the App Store



ARE YOU REGISTERED?

If you're already registered on kp.org, you're all set to start using your Kaiser Permanente app. If not, you'll need to go to kp.org/registernow to set up your account from a computer. Then use your new user ID and password to activate the app.

Certain features of My Health Manager apply only to care you receive at Kaiser Permanente facilities. Apple is a trademark of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc. Google Play is a trademark of Google Inc.

Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii

Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

UCCI HMO DENTAL INSURANCE



HMO Dental Plan: Dental Coverage is provided through a plan called United Concordia Dental. To access information on United Concordia's website, employee's can visit www.ucci.com. Alternatively, you can call (866) 357-3304 for customer service. Hawthorne School District's plan requires you to seek treatment from a dentist within the United Concordia provider network.

PLAN FEATURES	UNITED CONCORDIA HMO PLAN
Preventative	**Copay**
Periodic Exam, X-Rays, Fillings	$0
Basic Services	
Root Canal	$20-$40
Perio Scaling, Root Planing	$0
Gingivectomy	$0
Major Services	
Crown	$30-$40
Complete Denture (upper or lower)	$50
Extractions	$0
Incision and Drainage of Abscess	$0
Orthodontic Treatment—Adolescent	$1,500
Orthodontic Treatment—Adult	$2,000

FINDING A DENTAL PROVIDER:

Go to www.ucci.com or call (866) 357-3304 to find a United Concordia dentist near you.

DELTA DENTAL®

DELTA DENTAL INSURANCE



PPO Dental Plan: The Delta PPO plan is a Preferred Provider dental plan. The benefits cover a wide range of dental services. You may visit a PPO dentist and benefit from the negotiated rate or visit a non-network dentist. When you utilize a PPO dentist, your out-of-pocket expenses will be less. You may also obtain services using a non-network dentist; however, you will be responsible for the difference between the covered amount and the actual charges and you may be responsible for filing claims.

PLAN FEATURES	DELTA DENTAL PPO PLAN	
	PPO Network	**Out-of-Network**
Calendar Year Maximum	$1,500	$1,500
Preventative (Plan Pays)		
Cleanings, X-Rays	100%	100%
Basic Services (Plan Pays)		
Fillings, Sealants	100%	100%
Major Services (Plan Pays)		
Crowns, Inlays, Onlays	100%	100%
Bridges, Dentures, Implants	70%	50%

Dependent Coverage for this plan is subject to a contribution, via payroll deduction by the employee. Payroll deduction amounts are referenced in the EASE portal. For further assistance regarding these contributions please contact the Benefits Department

FINDING A DENTAL PROVIDER:

Go to www.deltadentalins.com or call (800) 765-6003 to find a Delta dentist near you.





Delta Dental — Virtual Consult:

Use your benefits to see a dentist online

A new virtual dentistry tool for members is here. Say hello to Delta Dental – Virtual Consult.

Virtual Consult connects Delta Dental members and dentists for real-time video appointments. It's totally secure and HIPAA-compliant, and it's available for free[1] with your existing Delta Dental PPO™ or Delta Dental Premier® plan[2].

When you have an urgent issue, even if it's after hours[3], Virtual Consult makes getting a dentist's advice simple. Even if you don't have a dentist that you see regularly, Virtual Consult makes urgent care, e-prescriptions and check-ins with Delta Dental dentists accessible from the comfort of your own home.

Virtual Consult is great if you…

- Are experiencing an urgent dental issue
- Don't have a regular dentist
- Can't take time off work or have difficulty visiting the dentist's office
- Aren't feeling well or visiting the dentist's office isn't recommended

1. If you have 100% coverage for oral evaluations, you are eligible to use Virtual Consult as a covered benefit. There are no additional costs to use the platform
2. Delta Dental PPO and Delta Dental Premier are open networks that allow you to visit any licensed dentist, either in the PPO network, where you will save the most on out-of-pocket costs, or the moderate-cost Premier network. Outside the Delta Dental network, there are no cost protections. When you visit a network dentist, you receive the advantage of no billing beyond the charges allowed by the plan and the submission of claims by dentists. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.
3. Please note that availability of Virtual Consult providers may vary based upon state and appointments are subject to schedule availability. Virtual Consult is available in AL, CA, DC, DE, FL, GA, LA, MD, MS, MT, NV, NY, PA, TX, UT, WV.

EYEMED VISION INSURANCE

EYEMED VISION PLAN: The EyeMed vision plan provides professional vision care and high quality lenses and frames through a broad network of optical specialists. You will receive richer benefits if you utilize a non-network provider, you will be responsible to pay all charges at the time of your appointment and will be required to file an itemized claim with VSP.

Personalized Coverage for All: Everyone on your plan gets the comprehensive vision coverage you expect, like eye exams, glasses, and savings on lens upgrades. Plus, with EyeMed Plus Providers, you get a $50 additional frame allowance and No Charge for exams.



Here's How it Works

- Create an account on eyemed.com
- Insight Network

PLAN FEATURES	EyeMed Vision Plans			
	Base Plan		Buy-Up Plan	
	In Network	Out of Network	In Network	Out of Network
Plus Provider Examination	100% Covered	Up to $40	100% Covered	Up to $40
Examination	$10 Copay	Up to $40	$10 Copay	Up to $40
Lenses				
Single Vision	100% Covered	Up to $30	100% Covered	Up to $30
Bifocal Vision	100% Covered	Up to $50	100% Covered	Up to $50
Trifocal Vision	100% Covered	Up to $70	100% Covered	Up to $70
Anti-Reflective Coating	$45-$68 Copay	None	$45-$68 Copay	None
Progressive Lenses	100% Covered (Standard)	Up to $50	100% Covered (Standard)	Up to $50
Frames	$120	Up to $84	$200	Up to $140
Contact Lenses				
Elective	$120 Allowance	Up to $84	$200 Allowance	Up to $140
Medically Necessary	100% Covered	Up to $300	100% Covered	Up to $300
Frequency				
Examination	12 Months		12 Months	
Lenses	24 Months		12 Months	
Frames	24 Months		24 Months	

FINDING A VISION PROVIDER:

Go to www.eyemed.com or call (866) 723-0513 to find an EyeMed Vision provider near you.

HealthEquity®

HSD

FLEXIBLE SPENDING ACCOUNTS

You can set aside money in Flexible Spending Accounts (FSA), administered by HealthEquity, before taxes are deducted to pay for certain health and dependent care expenses, lowering your taxable income and increasing your take home pay. Only expenses for services incurred during the plan year are eligible for reimbursement from your accounts. You choose how you want to receive reimbursement for your eligible expenses. You may use a debit card provided by HealthEquity, sign up for direct deposit to your bank account or you may have a check sent to your home.



Please remember that if you are using your debit card you must save your receipts in case HealthEquity needs a copy for verification. Also, all receipts should be itemized to reflect what product or service was purchased. Credit card receipts are not sufficient per IRS guidelines.

Health Care Spending Account (HCSA): This plan is used to pay for family expenses not covered under your health plans, such as deductibles, co-insurance, co-pays and expenses that exceed plan limits. Employees may defer up to $3,300 pre-tax per year.

Dependent Care Assistance Plan (DCAP): This plan is used to pay for the family's eligible expenses you incur for child care, or for the care of disabled dependents, while you work. Employees may defer up to $5,000 pre-tax per year.

Note: Although the Plan Year runs from October 1 through September 30, you will have the opportunity to still incur expenses after September 30 and get reimbursed.

The plan will allow a "grace period" through December 15, allowing you to incur expenses 2 1/2 months after the plan year ends on September 30. If you have not had the opportunity to incur expenses during the plan year, this provision allows you additional time to incur expenses to be submitted.

Eligible expenses will be those incurred from October 1 through December 15. Remember, should you not submit qualified health care claims to HealthEquity by the deadline, any amounts remaining in the account are forfeited.

Lincoln Financial Group®

VOLUNTARY LIFE INSURANCE

Voluntary term life insurance is provided through Lincoln Financial Group (LFG). This option offers employees the opportunity to buy coverage for themselves and their eligible dependents with the advantage of group term rates and simplified underwriting requirements.

A range of protection is available to suit your needs. If you're an active employee who works 20 hours per week or more, you can choose any amount from $10,000 to $500,000 of coverage, up to five times your basic annual salary. The guarantee issue amount for employees is $200,000. You can also choose to purchase additional amounts of coverage up to $500,000, with evidence of insurability (EOI).

Family Coverage: Lincoln Financial Group (LFG) gives you the option to extend coverage to your spouse and children. Your spouse, if underage 75, is eligible for any amount from $5,000 to $500,000 of coverage, not to exceed 100% of the employee's amount. The guarantee issue amount for spouse coverage is $50,000 and additional amounts of coverage can be purchased up to $500,000, with evidence of insurability. Children from birth through 26 years of age can be covered for amounts of $5,000 or $10,000 each.



Anyone who is newly eligible will be able to elect coverage up to the Guarantee Issue Amount without having to provide EOI. Anyone who is currently enrolled can increase coverage by 2 increments without EOI as long as it does not exceed the plan maximum. Anyone who did not elect during the initial enrollment time can also elect 2 increments without EOI.

VOLUNTARY SHORT TERM DISABILITY

Voluntary short term disability protects your income in the event you are disabled for longer than 14 calendar days. Lincoln Financial Group covers 35% of your weekly salary to a maximum benefit of $1,500/week. This benefit is up to 24 weeks of disability.

VOLUNTARY LONG TERM DISABILITY

Voluntary long term disability protects your income in the event you are disabled for longer than 180 calendar days. Lincoln Financial Group covers 60% of your monthly salary to a maximum benefit of $7,500/month. This benefit is to the insured employees Social Security Normal Retirement Age.

SUPPLEMENTAL BENEFITS

Why do you need Supplemental Insurance?

- Because unexpected illnesses and accidents happen
- Supplemental benefits are designed to compliment your core benefits

Supplemental Policies:

- Pay benefits directly to you, unless otherwise assigned, regardless of any other coverage you might have
- Help you cover out-of-pocket expenses: Deductibles, Co-pays & Loss of Income
- Are portable within 31 days of terminating employment
- Allow you to choose policies based on your needs at low group rates
- Processes claims as quickly as 1 business day

Policies Available:

CANCER PROTECTION

- Covers Internal Cancer, Clarke's Level III or higher, as well as Skin Cancer
- Pays a Lump Sum benefit upon initial diagnosis of $6,000 which builds by $500 each year one is cancer free
- Pays a Cancer Screening benefit for every covered person of $100 per calendar year
- Excellent coverage for all types of treatment, surgery, hospitalization & more

CRITICAL CARE

- Excellent coverage for all types of Critical Illnesses, including Heart Attack, Stroke, Coma, End Stage Renal Failure, Coronary Artery Bypass, & more
- Pays a Lump Sum benefit at initial occurrence of $7,500 which builds by $500 each year one is event free
- Pays towards hospitalization, continuing care & more

HOSPITAL CHOICE

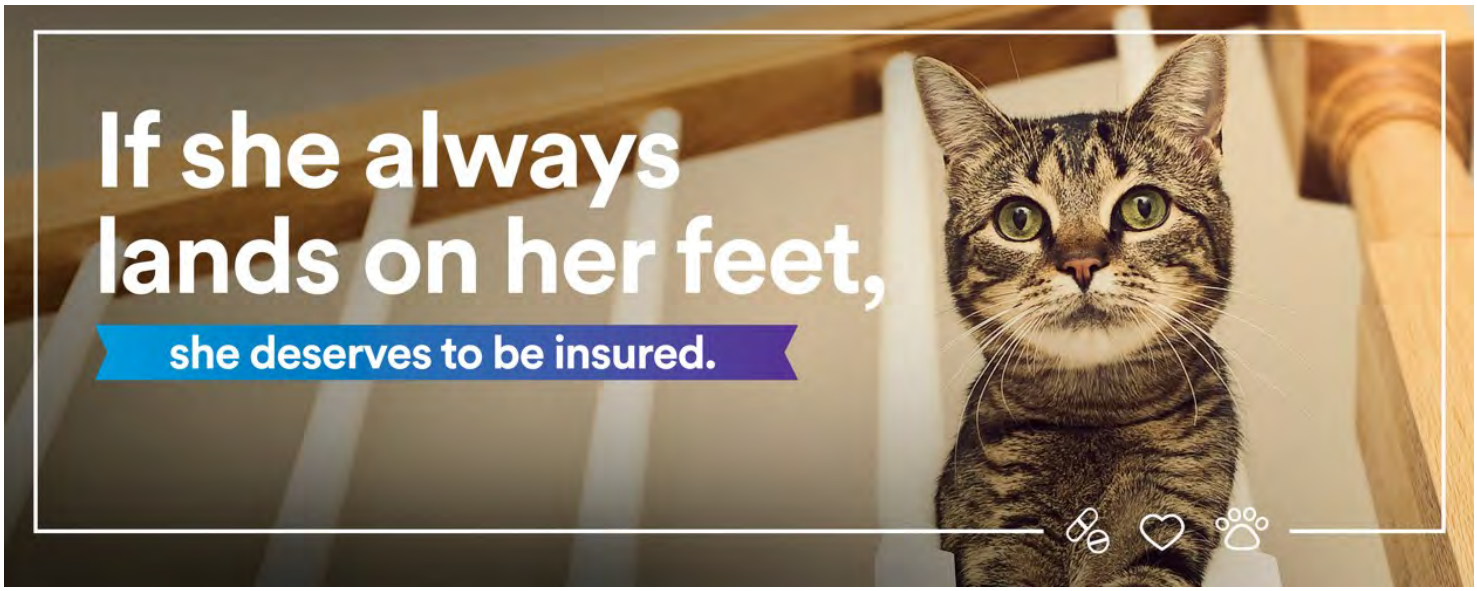
- Excellent coverage for any hospital related stay
- Can help prevent high deductibles and out-of-pocket expenses from derailing life plans
- Pays you a Physician Visit benefit for the Employee (3 visits) or Family (6 visits) at $25 per calendar year

ACCIDENT ADVANTAGE

- Covers on and off-the-job accidents large and small
- Pays towards injuries, office visits, physical therapy, hospitalization & more
- Great for active families
- Pays you an annual $60 wellness benefit for the family per calendar year.

HSD

MetLife | Pet Insurance



No matter if they're clumsy or able to defy gravity, our furry family members make life more interesting However, when the unexpected happens to them, you need coverage that can help ease the burden of veterinary expenses. MetLife Pet Insurance can help. Here's how it works:

1. **ENROLL**—Select and enroll in the coverage that's right for you and your pet and download our mobile

2. **CARE**—Take your pet to the vet and pay the bill; manage your pet's health and wellness using the app

3. **COVER**—Send the bill and your claim documents to us and receive reimbursement by check or direct deposit if the claim expense is covered under the policy.

It's that simple. A small monthly payment today can help keep your pet healthy and happy. Call 1-800-GET-MET8 for a quote today.



Help protect your dogs and cats while enjoying benefits like flexible coverage with up to 90% reimbursement and freedom to visit any US licensed vet, optional Preventive Care coverage, 24/7 access to Telehealth Concierge Services, and discounts up to 30% and additional offers on pet care, where available.

HSD

ease

Enrollment Guide at a Glance

1. Log in to Ease per the instructions you have received from your HR administrator or Broker. For optimal performance it is recommended that you use Chrome or Firefox as your browser.

2. Click Start Enrollment to begin your enrollment.

3. Follow the prompts on each page to complete your benefit enrollment. Click Continue to proceed to the next section.

4. Verify your personal information is correct and enter in any of your dependent information.

5. If requested during the enrollment process, provide any emergency contacts, employment documents, Medicare status, previous/current coverage and/or health information.

6. Please Select ✓ ✗ your benefit by selecting Enrolled ✓ ✗ or Waived ✓ ✗ for each plan. Click to Continue proceed to the next benefit.

7. You will then be prompted to provide any missing data. Once you have done this, you will be able to review and sign your forms Sign Forms using your mouse or mobile device

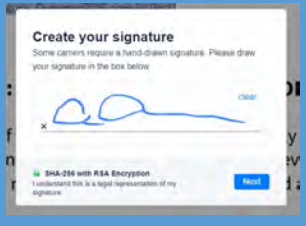
8. Before you review your forms



type your name.

THEN

Sign your signature and follow the



prompts to finish

9. If you have questions, reach out to your HR administrator or Broker.

RESOURCES AND CONTACTS

Below is a list of insurance carrier contacts should you require assistance with your benefit questions following open enrollment.

Anthem Customer Service
1-800-825-5541

Kaiser Permanente Customer Service
1-800-464-4000

MEDICAL - ANTHEM BLUE CROSS		
Group ID: HMO 57AHD, PPO 40985	HMO and PPO: (800) 825-5541 Costco Rx Mail Order : (800)-6076861, Navitus Rx:	www.anthem.com/ca/sisc
MEDICAL - KAISER PERMANENTE		
Group ID: 100539	Member Services: (800) 464-4000	www.kp.org
DENTAL - DELTA DENTAL		
Group ID: 7026	Member Services: (800) 765-6003	www.deltadentalins.org
DENTAL - UNITED CONCORDIA		
Group ID: 740254	Member Services: (866) 357-3304	www.ucci.com
VISION - EYEMED		
Group ID: 1040584	Member Services: (866) 723-0513	www.eyemed.com
LIFE/AD&D/STD/LTD - LINCOLN FINANCIAL		
Group ID: 1536643	Member Services: (800) 423-2765	www.lincolnfinancial.com
FLEXIBLE SPENDING ACCOUNTS - HEALTHEQUITY		
	Member Services: (877) 924-3967	www.myhealthequity.com
VOLUNTARY - AFLAC		
	Member Services: (800) 992-3522	www.aflac.com
HEATH BENEFIT PARTNERS		
	Member Services: (866) 770-1589	https://heathbp.com

ONLINE ENROLLMENT

All information can be viewed and selected on our online site.
Please visit **www.Hawthorne.EASE.com** for more information.

Note: If you are unable to resolve your issues or questions with the insurance carriers, please contact the District Benefits Department .

LEGAL INFORMATION ABOUT YOUR PLAN

REQUIRED NOTICES

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Your plans comply with these requirements.

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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Health Insurance Portability & Accountability Act Non-discrimination Requirements

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

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

Special Enrollment Rights

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

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

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section).

To request special enrollment or obtain more information, contact your Benefits Department. "HIPAA Special Enrollment Opportunities" include:

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

“Change in Status” Permitted Midyear Election Changes

Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved “change in status” as defined by the IRS.

Examples of permitted “change in status” events include:

- Change in legal marital status (e.g., marriage, divorce or legal separation)
- Change in number of dependents (e.g., birth, adoption or death)
- Change in eligibility of a child
- Change in your / your spouse’s / your domestic partner’s employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse’s / your domestic partner’s benefits coverage
- A relocation that impacts network access
- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- Loss of other coverage

You must notify the Benefits Department within 30 days of the above change in status, with the exception of the following which require notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)
- Divorce or legal separation resulting in a loss of coverage
- A dependent’s eligibility ceases resulting in a loss of coverage

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

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

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you.

HSD’s Pledge regarding Health Information

We understand that health information about you and your health is personal.

We are committed to protecting health information about you.

This notice will tell you the ways in which we may use and disclose health information about you.

We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by Law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the notice that are currently in effect.
- The Plan will use Your Health Information for:

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

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees.

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

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

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

Law Enforcement: We may disclose your health information for law enforcement purposes, or in response to a valid subpoena or other judicial or administrative request.

Public Health: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation).

Your Rights Regarding Your Health Information

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

- Request a restriction on certain uses and disclosures of your information, where concerning a service already paid for;
- Obtain a paper copy of the Notice of Health Information Practices by requesting it from the plan privacy officer;
- Inspect and obtain a copy of your health information;
- Request an amendment to your health information;
- Obtain an accounting of disclosures of your health information;
- Request communications of your health information be sent in a different way or to a different place than usual (for example, you could request that the envelope be marked "Confidential" or that we send it to your work address rather than your home address);
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction, amendment or other request;
- Notify you of any breaches of your personal health information within 60 days or 5 days if conducting business in California;
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice.

The plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you.

For More Information or to Report a Problem

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer; or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.

Important Information on how Health Care Reform Affects Your Plan

Primary Care Provider Designations

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

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

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 Benefits Department.

Grandfathered Plans

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

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

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Pre-existing Condition Exclusion

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

Important Information about COBRA Continuation Coverage and other Health Coverage Alternatives

This notice has important information about your right to continue your health care coverage in your district's plan, as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.healthcare.gov or call 800.318.2596.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

Qualifying events that would prompt a COBRA notification:

- Termination of employment (18 months of COBRA)
- Reduction in hours of employment (18 months of COBRA)
- Death of employee (36 months of COBRA for the spouse and dependents)
- Divorce or legal separation (36 months of COBRA for the ex-spouse)
- Entitlement to Medicare (36 months of COBRA for the spouse and dependents)
- Loss of dependent child status (36 months of COBRA for the dependent)

Federal law requires that most group health plans (including this plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") from the list below may qualify to elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the plan because he or she is no longer a dependent under the plan

Contact your Benefits Department to determine eligibility for spouse and dependents.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable 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 should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries. Contact your Benefits Department for specific start and end dates for COBRA coverage.

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify the Benefits Department of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage.

If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit http://www.dol.gov/ebsa/publications/cobraemployee.html.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

Other coverage options may cost less. If you choose to elect continuation coverage, additional information about payment will be provided to you after your election is received by the plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.healthcare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in the Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For More Information

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Benefits Department. If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Benefits Department.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assistant in your area who you can talk to about the different options, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep your employer informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

Important Information about Payment

First payment for continuation coverage. You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the plan. You're responsible for making sure that the amount of your first payment is correct. You may contact the Benefits Department to confirm the correct amount of your first payment.

Periodic payments for continuation coverage. After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary may be obtained by contacting the Benefits Department. The periodic payments can be made on a monthly basis.

Under the plan, each of these periodic payments for continuation coverage is due on a specified date for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the plan will continue for that coverage period without any break. The plan will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments. Although periodic payments are due on specified dates (contact the Benefits Department for this information), you'll be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period.

If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the plan. Contact your Plan Administrator for information for where your first payment and all periodic payments for continuation coverage should be sent.

Separate USERRA Rights for Military Service: The COBRA health care coverage continuation rights discussed above are separate from USERRA health care coverage continuation rights for qualifying military service.

If you leave employment to enter military service, you should contact the Benefits Department to determine whether you also have USERRA health care coverage continuation rights.

OMB Control Number 1210-0123

Employee Rights & Responsibilities under the Family Medical Leave Act (50 or more employees) Basic Leave Entitlement

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

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

Military Family Leave Entitlements

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

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

Benefits & Protections

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

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

Eligibility Requirements

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

Definition of Serious Health Condition

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

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

Use of Leave

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

Substitution of Paid Leave for Unpaid Leave

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

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable.

When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

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

Employer Responsibilities

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

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

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

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

Enforcement

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

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

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

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

Uniformed Services Employment & Reemployment Rights Act Notice of 1994, Notice of Right to Continued Coverage under USERRA.

Right to Continue Coverage

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

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

How to Continue Coverage

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

What Happens if You do not Elect to Continue Coverage?

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

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

Premium for Continuing Your Coverage

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

Length of Time Coverage Can Be Continued

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

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

Reporting to Work / Applying for Reemployment

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

Definitions

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

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 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, 2015. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration www.dol.gov/ebsa

1-866-444-EBSA (3272)

OMB Control Number 1210-0137

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

ANNUAL NOTICES

ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. The following is a brief summary of the annual notices:

- Medicare Part D Notice of Creditable Coverage: Plans are required to provide each covered participant and dependent a Certificate of Creditable Coverage to qualify for enrollment in Medicare Part D prescription drug coverage when qualified without a penalty/ This notice also provides a written procedure for individuals to request and receive Certificates of Creditable Coverage.
- HIPAA Notice of Privacy Practices: This notice is intended to inform employees of the privacy practices followed by Hawthorne School District group health plan. It also explains the federal privacy rights afforded to you and the members of your family as plan participants covered under a group plan.
- Women's Health and Cancer Rights Act (WHCRA): The Women's Health and Cancer Rights Act (WHCRA) contains important protections for breast cancer patients who choose breast cancer patients who choose breast reconstruction with a mastectomy. The U.S. Departments of Labor and Health and Human Services are in charge of this act of law which applies to group health plans if the plans or coverage provide medical surgical benefits for a mastectomy.
- Newborns' and Mothers' Health Protection Act: The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time a mother and her newborn child are covered for a hospital stay following childbirth.
- Special Enrollment Rights: Plan participants are entitled to certain special enrollment rights outside of Hawthorne School District open enrollment period. This notice provides information on special enrollment periods for loss of prior coverage or the addition of a new dependent.
- Medicaid & Children's Health Insurance Program: Some states offer premium assistance programs for those who are eligible for health coverage from their employers, but are unable to afford the premiums. This notice provides information on how to determine if your state offers a premium assistance program.

Note: **Hawthorne School District has posted all federally required annual notices on the Hawthorne.EASE site listed on RESOURCES AND CONTACTS page for you to download and read at your convenience.**

MEDICAID CONTACTS BY STATE

HSD

	ALABAMA – Medicaid	MINNESOTA – Medicaid	PENNSYLVANIA – Medicaid
Website:	www.myalhipp.com	http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance	http://www.dpw.state.pa.us/hipp
Phone:	1-855-692-5447	1-800-657-3739	1-800-692-7462
	ALASKA – Medicaid	**MISSOURI – Medicaid**	**RHODE ISLAND – Medicaid**
Website:	http://health.hss.state.ak.us/dpa/programs/medicaid/	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	www.ohhs.ri.gov
Phone:	(Outside of Anchorage) 1-888-318-8890	573-751-2005	401-462-5300
Phone:	(Anchorage): 907-269-6529		
	COLORADO – Medicaid	**MONTANA – Medicaid**	**SOUTH CAROLINA – Medicaid**
Website:	http://www.colorado.gov/hcpf	http://medicaid.mt.gov/member	http://www.scdhhs.gov
Phone:	1-800-221-3943	1-800-694-3084	1-888-549-0820
	FLORIDA – Medicaid	**NEBRASKA – Medicaid**	**SOUTH DAKOTA - Medicaid**
Website:	https://www.flmedicaidtplrecovery.com/	www.ACCESSNebraska.ne.gov	http://dss.sd.gov
Phone:	1-877-357-3268	1-855-632-7633	1-888-828-0059
	GEORGIA – Medicaid	**NEVADA – Medicaid**	**TEXAS – Medicaid**
Website:	http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)	http://dwss.nv.gov/	https://www.gethipptexas.com/
Phone:	1-800-869-1150	1-800-992-0900	1-800-440-0493
	INDIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**	**UTAH – Medicaid and CHIP**
Website:	http://www.in.gov/fssa	http://www.dhhs.nh.gov/oii/documents/hippapp.pdf	Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip
Phone:	1-800-889-9949	603-271-5218	1-866-435-7414
	IOWA – Medicaid	**NEW JERSEY – Medicaid and CHIP**	**VERMONT– Medicaid**
Website:	www.dhs.state.ia.us/hipp/	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	http://www.greenmountaincare.org/
Phone:	1-888-346-9562	Medicaid: 609-631-2392 CHIP: 1-800-701-0710	1-800-250-8427
	KANSAS – Medicaid	**NEW YORK – Medicaid**	**VIRGINIA – Medicaid and CHIP**
Website:	http://www.kdheks.gov/hcf/	http://www.nyhealth.gov/health_care/medicaid/	Medicaid: http://www.coverva.org/programs_premium_assistance.cfm CHIP: http://www.coverva.org/programs_premium_assistance.cfm
Phone:	1-800-792-4884	1-800-541-2831	Medicaid: 1-800-432-5924 CHIP: 1-855-242-8282
	KENTUCKY – Medicaid	**NORTH CAROLINA – Medicaid**	**WASHINGTON – Medicaid**
Website:	http://chfs.ky.gov/dms/default.htm	http://www.ncdhhs.gov/dma	http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx
Phone:	1-800-635-2570	919-855-4100	1-800-562-3022 ext. 15473
	LOUISIANA – Medicaid	**NORTH DAKOTA – Medicaid**	**WEST VIRGINIA – Medicaid**
Website:	http://www.lahipp.dhh.louisiana.gov	http://www.nd.gov/dhs/services/medicalserv/medicaid/	www.dhhr.wv.gov/bms/
Phone:	1-888-695-2447	1-800-755-2604	1-877-598-5820, HMS Third Party Liability
	MAINE – Medicaid	**OKLAHOMA – Medicaid and CHIP**	**WISCONSIN – Medicaid and CHIP**
Website:	http://www.maine.gov/dhhs/ofi/public-assistance/index.html	http://www.insureoklahoma.org	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone:	1-800-977-6740 / TTY 1-800-997-6741	1-888-365-3742	1-800-362-3002
	MASSACHUSETTS – Medicaid and CHIP	**OREGON – Medicaid**	**WYOMING – Medicaid**
Website:	http://www.mass.gov/MassHealth	http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov	http://health.wyo.gov/healthcarefin/equalitycare
Phone:	1-800-462-1120	1-800-699-9075	307-777-7531



1-866-770-1589

Matthew Heath, Account Executive

Candice Bright, Executive Account Manager

This brochure provides an overview of some of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment. Neither is it a legal plan document. If there is a disagreement between this guide and the plan documents, the plan documents will govern.

In addition, the plans described in this brochure are subject to change without notice. Continuation of any benefit plan or coverage is at the District's discretion and in accordance with federal and state laws. If you need additional information or have any questions about the benefit program, please contact the Benefits Office.

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