LE LYCÉE FRANÇAIS DE LOS ANGELES







2025 - 2026 BENEFITS GUIDE

EFFECTIVE NOVEMBER 1, 2025 – OCTOBER 31, 2026

ANNUAL HEALTH PLAN
IMPORTANT NOTICES

NOTICE: CMS PART D NOTICE OF CREDITABLE OR NON-CREDITABLE COVERAGE

When you or a family member becomes eligible for Part D (Medicare's prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain "creditable" coverage (i.e., coverage which on average expects to pay at least as well as Part D expects to pay on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity to avoid future penalties.

Below are highlights to note:

- A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.
- The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1% of Part D base premium for each month you are late.
- When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).
- The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

The information below indicates whether prescription drug coverage under our plan is creditable.

Creditable Coverage	Non-Creditable Coverage
All Plans	None (all plans are creditable)

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at **https://www.shiphelp.org**.

REMEMBER: If you have creditable coverage through our plan, keep this Notice as proof. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this Notice when you join to show you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

DATE: 11/01/2025
NAME OF ENTITY/SENDER: Le Lycee Francais de Los Angeles Inc
CONTACT--POSITION/OFFICE: Human Resources
ADDRESS: 3261 Overland Avenue, Los Angeles, CA 90034
PHONE NUMBER: (310) 836-3464

INTRODUCTION

Welcome!

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

Benefit Options for 2025-2026

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

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

- **Medical coverage through Anthem Blue Cross**
- **Dental coverage through Anthem Blue Cross**
- **Vision coverage through Anthem Blue Cross**
- **Basic Life and AD&D coverage through The Standard**
- **Voluntary Life and AD&D coverage through The Standard**
- **Voluntary Accident and Critical Illness coverage through Sun Life**
- **Employee Assistance Program (EAP) through Anthem Blue Cross**

Please note: Medicare Creditable notice can be located on page 2

CA Individual Mandate

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

When To Enroll

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

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

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



ELIGIBILITY

Open Enrollment

Open enrollment occurs one time each year. During this time, you may add or remove dependents from your coverage, change your coverage level, or change your benefit elections without experiencing a qualifying event. The benefits and coverage you select during this open enrollment period will remain in effect until October 31, 2026, unless you experience a qualifying life event and submit plan changes.



Eligibility

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

Dependents:
As an eligible employee, you may cover your legal spouse or registered domestic partner, dependent child(ren) up to the age of 26 (regardless of their student status) and unmarried dependent child(ren) over the carrier age limits who are physically or mentally incapable of self-support.

Qualifying Events for Changing Benefits

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

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

INSURANCE BASICS

Medical HMO

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

Who should consider opting for a HMO?

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

Medical PPO

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

Who should consider opting for a PPO?

If you are looking for greater flexibility to book appointments with providers who are in the PPO network (as well as those out-of-network) without a referral. It's important to note that you may pay a higher rate if you choose to go out-of-network. If you travel often, or have covered dependents who live out of state a PPO plan might be a better fit.

Dental HMO (DHMO)

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

Dental PPO (DPPO)

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



FREQUENTLY ASKED QUESTIONS

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

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

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

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

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

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

What is In-Network?
Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members at a set rate. Health care providers are not able to charge insureds more than the negotiated fee set by the insurance provider.

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

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



MEDICAL COVERAGE: HMO OPTIONS

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

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

	Anthem Value HMO	Anthem Value HMO	Anthem Premier HMO
	California Care HMO Network	Select HMO Network	Vivity HMO Network
Annual Deductible Calendar year	None	None	None
Annual Out-of-Pocket Max Calendar year	$2,500 Individual $5,000 Family	$2,500 Individual $5,000 Family	$1,500 Individual $3,000 Family
Physicians Services			
Primary Care	$20 Copay	$20 Copay	$10 Copay
Specialist Visits	$40 Copay	$40 Copay	$10 Copay
Preventive Care	No Charge	No Charge	No Charge
Hospital Services			
Inpatient Hospitalization	$250 Copay/day up to 3 days/admit	$250 Copay/day up to 3 days/admit	No Charge
Outpatient Surgery	$125 Copay	$125 Copay	No Charge
Tests			
Advanced Imaging	$125 Copay/Day	$125 Copay/Day	$125 Copay/Day
Diagnostic X-ray/Lab	No Charge	No Charge	No Charge
Urgent / Emergency Care Visits			
Urgent Care	$20 Copay	$20 Copay	$10 Copay
Emergency Room (Waived if admitted)	$200 Copay	$200 Copay	$200 Copay
Prescriptions (Retail 30-day supply)			
Brand Name Rx Deductible	None	None	None
Tier 1: Generic	1a: $5 Copay; 1b: $20 Copay	1a: $5 Copay; 1b: $20 Copay	1a: $5 Copay; 1b: $20 Copay
Tier 2: Preferred Brand Name	$40 Copay	$40 Copay	$40 Copay
Tier 3: Non-Preferred Brand Name	$60 Copay	$60 Copay	$60 Copay
Tier 4: Specialty/ Specialty Drugs	30% up to $250	30% up to $250	30% up to $250

Prescriptions available through mail order. See your summary of benefits for full details.

MEDICAL COVERAGE: PPO OPTION

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

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

	Anthem Classic PPO	
	Prudent Buyer PPO Network	
	In-Network	Out-of-Network
Annual Deductible Calendar Year	$750 Individual $2,250 Family	$2,250 Individual $6,750 Family
Annual Out-of-Pocket Max. Calendar Year	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
Physicians Services		
Primary Care	$30 Copay	40% Coinsurance*
Specialist Visits	$50 Copay	40% Coinsurance*
Preventive Care	No Charge	40% Coinsurance*
Hospital Services		
Inpatient Hospitalization	20% Coinsurance*	40% Coinsurance up to $1,000/day*
Outpatient Surgery	20% Coinsurance*	40% Coinsurance up to $350/admit*
Tests		
Advanced Imaging	20% Coinsurance*	40% Coinsurance up to $800/service*
Diagnostic X-ray/Lab	20% Coinsurance*	40% Coinsurance*
Urgent / Emergency Care Visits		
Urgent Care	$30 Copay	40% Coinsurance*
Emergency Room (Waived if admitted)	$150 Copay + 20%*	Same as In-Network
Prescriptions (Retail 30-day supply)		
Brand Name Rx Deductible	None	None
Tier 1: Generic	1a: $5 Copay; 1b: $20 Copay	50% up to $250
Tier 2: Preferred Brand Name	$30 Copay	50% up to $250
Tier 3: Non-Preferred Brand Name	$50 Copay	50% up to $250
Tier 4: Specialty/Specialty Drugs	30% up to $250	50% up to $250

Prescriptions available through mail order. See your summary of benefits for full details.

*** After Deductible**

At home or on the go, doctors and mental health professionals are here for you.

Using LiveHealth Online, you can have a private video visit on your smartphone, tablet or computer.



When you're not feeling well you can get the support you need easily using LiveHealth Online. Whether you have a cold, you're feeling anxious or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best. Using LiveHealth Online you can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet or computer from home or anywhere.

On LiveHealth Online, you can:

- **See a board-certified doctor 24/7.** You don't need an appointment to see a doctor. They're always available to assess your condition and send a prescription to the pharmacy you choose, if needed.[1] It's a great option when you have pink eye, a cold, the flu, a fever, allergies, a sinus infection or another common health issue.
- **Visit a licensed therapist in four days or less.**[2] Have a video visit with a therapist to get help with anxiety, depression, grief, panic attacks and more. Schedule your appointment online or call **1-888-548-3432** from **8 a.m. to 8 p.m.**, seven days a week.
- **Consult a board-certified psychiatrist within two weeks.**[3] If you're over 18 years old, you can get medication support to help you manage a mental health condition. To schedule your appointment call **1-888-548-3432** from **8 a.m. to 8 p.m.**, seven days a week.

You've got access to affordable and convenient care

Video visits using LiveHealth Online are usually $59 or less for a medical doctor visit, and a 45-minute therapy or psychiatry session usually costs the same as an office mental health visit.

Sign up for LiveHealth Online today – it's quick and easy

Go to **livehealthonline.com** or download the app and register on your phone or tablet.

App Store | Google play

See a Spanish-speaking doctor with Cuidado Médico on LiveHealth Online

Anthem LiveHealth ONLINE

Designed with you in mind

When you enroll in Building Healthy Families, you can count on personalized support at every stage, from family planning and pregnancy through the toddler years. Plus, if you have a family story that includes adoption, surrogacy, or single parenthood, the resources, tools, and information on your profile will be tailored to what you need. Depending on your situation, you'll have unlimited access to:

Tools to help you stay organized

- Log newborn feedings, diaper changes, growth, vaccinations, and your child's developmental milestones.
- Monitor prenatal health risks, such as blood pressure and weight.

Health and wellness expertise for you and your family

- Explore a library with thousands of educational articles and videos on everything from family planning to parenting tips.
- Connect with a maternity nurse and access virtual lactation support, if needed.

Personalized pregnancy support

- Chat with a Family Care Coach during pregnancy for help navigating your Building Healthy Families experience.
- Receive updates on your pregnancy progress, like development of your baby and body changes.

It's exciting to watch your family grow, but that doesn't mean there aren't challenges along the way. Building Healthy Families can help you nurture your family's health and tackle every stage of growth with confidence.



Earn rewards for enrolling in Building Healthy Families

Log in to Sydney Health or **anthem.com/ca** and go to *My Health Dashboard*, then *My Rewards* to learn more.

Enroll today

1. Visit **anthem.com/ca** or log in to Sydney Health.
2. Find *Featured Programs* at the bottom of the homepage.
3. Select **View All** then choose the **Building Healthy Families** tile.

You can also scan this QR code with your phone's camera to get started.

DENTAL COVERAGE

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

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

	Anthem Dental HMO	Anthem Dental PPO	
		In-Network	Out-of-Network*
Benefit Description & Procedure Code			
Annual Deductible Individual/Family	None	$50 / $150 (Waived for Preventive Care)	$50 / $150 (Waived for Preventive Care)
Annual Maximum Benefit ** Per Member Enrolled	Unlimited	$1,500	$1,500
Preventive & Diagnostic Services			
Prophylaxis (Cleaning) D1110	No Charge; Additional: $45 Copay	Plan 100%; You 0%	Plan 100%; You 0%
Bitewing X-rays D0272	No Charge	Plan 100%; You 0%	Plan 100%; You 0%
Basic Services			
Amalgam Restoration (Filling) one surface D2140	No Charge	Plan 80%; You 20%	Plan 80%; You 20%
Endodontics Therapy (Root Canal) D3310	$45 Copay	Plan 80%; You 20%	Plan 80%; You 20%
Major Services			
Porcelain Crown D2750	$185 Copay	Plan 50%; You 50%	Plan 50%; You 50%
Dentures D5110	$175 Copay	Plan 50%; You 50%	Plan 50%; You 50%
Orthodontic Benefits			
Orthodontic Benefit - Child & Adult	$1,695 / $1,895	Plan 50%; You 50% (Child Only)	Plan 50%; You 50% (Child Only)
Lifetime Maximum Benefit	N/A	$1,500	$1,500

Only partial coverage details provided above. For full in-network and out-of-network plan details, please review the benefit summaries and Evidence of Coverage booklets.

*Members are subject to charges above the allowed out-of-network (OON) reimbursable charge since services are rendered by non-contracted providers. This is called balance billing.

**Annual Maximum is based on the calendar year.

PLEASE NOTE:

- If you elect Dental HMO (DHMO) coverage, you must select a contracted dentist from the DHMO Provider list. All care must be provided by the primary dentist.
- The Dental PPO (DPPO) plan provides you with the flexibility to receive services with a dental professional In-Network or Out-of-Network. As a suggestion, prior to receiving services outside of preventive care, ask your dentist to request a predetermination or estimate on the planned services with **Le Lycée Français de Los Angeles**. This will allow you to see what services will be performed, what will be covered by your plan and what amount you will be responsible for.

VISION COVERAGE

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

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

	Anthem Vision	
	In-Network	Out-of-Network
Basic Eye Exam	$10 Copay	Plan pays up to $42
Frames	$130 Allowance + 20% off the remaining balance	Plan pays up to $45
Single Vision Lenses	$25 Copay	Plan pays up to $40
Bifocal Lenses	$25 Copay	Plan pays up to $60
Trifocal Lenses	$25 Copay	Plan pays up to $80
Medically Necessary Contacts (in lieu of frames)	Covered 100%	Plan pays up to $210
Elective Disposable Contact Lenses (in lieu of frames)	$130 Allowance	Plan pays up to $105
Eye Exam Benefit Frequency	Once Every Calendar Year	Same as In-Network
Frame Benefit Frequency	Once Every Other Calendar Year	Same as In-Network
Lenses Benefit Frequency	Once Every Calendar Year	Same as In-Network



HOW TO FIND A PROVIDER

How To Find an Anthem Medical Provider

1. Visit https://www.anthem.com/ca, and select "Find Care" at the top right corner
2. There are two ways to search for a doctor
    a. To search as a member: click on "Log In" with your Username and Password
    b. To search as a guest: click on "Basic search as a guest" and follow steps below
3. If searching as guest, complete the following fields:
    a. Select the type of plan or network: Medical Plan or Network
    b. Select the state where the plan or network is offered: California
    c. Select how you get health insurance: Medical (Employer-Sponsored)
    d. Select a plan/network
        i. For the HMO CA Care Network plan: California Care HMO
        ii. For the HMO Select Network plan: Select HMO
        iii. For the HMO Vivity Network plan: Vivity HMO
        iv. For the PPO plan : Prudent Buyer PPO/EPO
4. Click "Continue"
5. Enter your City, County, or ZIP
6. Select the type of Care Provider: Primary Care, Behavioral Health, Lab, Imaging, or Hospital
7. Relevant results will be displayed

Important Information about electing a PCP in Network (HMO) plans

- All HMO enrollees must select a PCP and designate their PCP #. If you enter an invalid PCP # or leave this blank, you will be auto assigned to a provider based on your home zip code. If you receive an ID with an incorrect PCP listed, please contact your carrier member services to correct.
- If you decide to change your PCP at any time, you can do this by phone or online.

Information about the PPO plan

- You have the option of choosing a primary care provider (PCP) to guide your care (it is recommended but not required). You can see a specialist without a referral.
- Using in-network doctors and health care facilities may keep your costs lower.
- You can choose out-of-network doctors or facilities, but your costs may be higher.
- You'll pay an annual amount called a deductible before the plan begins to pay for covered costs. Once you meet your deductible, you pay a copay or coinsurance amount and the plan pays the rest of covered costs.
- Once you meet an annual limit on your payments called an out-of-pocket maximum, your plan pays 100% of covered costs.

Finding a Dentist:

Visit https://www.anthem.com/ca and click "Find Care" at the top right corner

1. There are two ways to search for a dentist
    a. To search as a member: click on "Log In" with your Username and Password
    b. To search as a guest: click on "Basic search as a guest" and follow steps below
2. If searching as guest, complete the following fields:
    a. Select the type of plan or network: Dental Plan or Network
    b. Select the state where the plan or network is offered: California
    c. Select how you get health insurance: Dental
    d. Select a plan/network
        i. For the DHMO plan: Dental Net HMO
        ii. For the DPPO plan: Dental Complete
3. Click "Continue"
4. Enter your City, County, or ZIP
5. Select the type of Care: Dentist, Oral Surgeon, Orthodontist, Periodontist, Pediatric Dentist, or Endodontist
6. Relevant results will be displayed

Finding an Eye doctor:

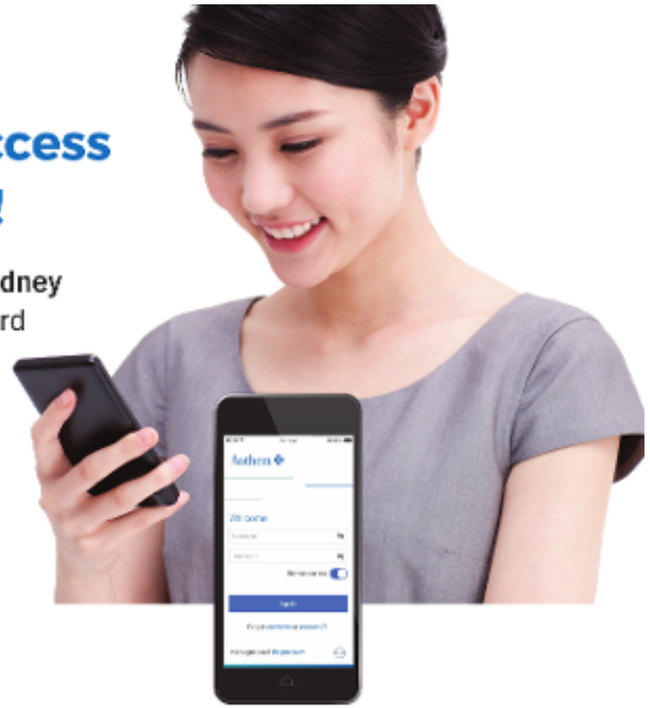
Visit https://www.anthem.com/ca and click "Find Care"

1. There are two ways to search for an eye doctor
    a. To search as a member: Click on "Log In" with your Username and Password
    b. To search as a guest: click on "Basic search as a guest" and follow steps below
2. If searching as guest, complete the following fields:
    a. Select the type of plan or network: Vision Plan or Network
    b. Select the state where the plan or network is offered: California
    c. Select how you get health insurance "Vision"
    d. Select a plan/network: Blue View Vision
3. Click "Continue"
4. Enter your City, County, or ZIP
5. Select the type of Care Provider: Ophthalmologist, Optical Store, or Optometrist
6. Relevant results will be displayed

You've got quick access to your health care!

Register on **anthem.com/ca** or the **Sydney** mobile app.* Have your member ID card handy to register





From your computer

1. Go to **anthem.com/ca/register**
2. Provide the information requested
3. Create a username and password
4. Set your email preferences
5. Follow the prompts to complete your registration

From your mobile device

1. Download the free **Sydney** mobile app and select **Register**
2. Confirm your identity
3. Create a username and password
4. Confirm your email preferences
5. Follow the prompts to complete your registration

It's easy. Everything you need to know about your plan — including medical — in one place. Making your health care journey simple, personal — all about you.

Need help signing up?
Call us at **1-866-755-2680**.

Anthem



Focus on your well-being and earn rewards up to $200

The more activities you complete, the greater your reward

The Wellbeing Solutions program connects you with easy-to-use digital health and wellness tools that can help you stay your best. When you complete any of the activities listed below sponsored by your employer, you'll earn rewards to put toward electronic gift cards for select retailers. You choose the activities you'd like to complete to receive the maximum of $200.

Activity Type	Activities	Amount
Preventive care	Have an annual preventive wellness exam or well woman exam with your doctor	$25
	Get an annual cholesterol test	$20
	Have a colorectal cancer screening (ages 45 and older)	$25
	Have a routine mammogram (women ages 40 to 74)	$25
	Have an annual eye exam	$25
	Get an annual flu shot	$20

Anthem

Activity Type	Activities	Amount
Condition management programs	ConditionCare: Work one on one with your health coach and earn rewards for participating in and completing the program[2]	Up to $50 ($20/$30)
	Building Healthy Families: Support is available through the Sydney℠ Health app wherever you are in your family planning process, such as trying to conceive or raising your toddler[3]	Up to $40 ($10/$10/$10/$10)
	Well-being Coach – Weight Management: Receive one-on-one coaching by phone as you complete your goal to earn a reward[4]	$25
	Well-being Coach – Tobacco Cessation: Receive one-on-one coaching by phone as you complete your goal to earn a reward[5]	$25
Digital & wellness activities	Log in to your Anthem account	$5
	Connect a fitness or lifestyle device	$5
	Complete a health assessment and receive tailored health recommendations	$20
	Complete action plans around eating healthy, weight management, and physical activity	Up to $25 ($5 per action plan)
	Track your steps	Up to $60 ($2 per 50,000 steps tracked)
	Complete Well-being Coach digital daily check-ins[7]	Up to $20 ($4 per milestone)
	Update your contact information	$10

Well-being Coach can help you meet your goals

The Well-being Coach digital coaching app offers you 24/7 personalized support. Well-being Coach can help you maintain a healthy weight, quit tobacco, and improve your nutrition, exercise habits, mindfulness, and sleep. If you need extra support with weight management or quitting tobacco, talk to a certified health coach.



Earn rewards

Here's how and when you'll earn rewards for completing the activities already mentioned.

Preventive care: Simply visit your doctor for any of the screenings or appointments listed in the chart. Your rewards are added to your account after your claim is processed, which may take up to 60 days.

Condition management: Rewards are added to your account as you meet certain benchmarks or complete a program. Programs include: ConditionCare (for asthma, diabetes, and heart or lung conditions), Building Healthy Families, and Well-being Coach for weight management and tobacco cessation.

Digital and wellness activities: Log in to the Sydney Health app or **anthem.com/ca** to complete available activities, such as taking a health assessment, participating in the Well-being Coach digital program, and tracking your steps. Rewards are added to your account as activities are completed.

Use your rewards toward electronic gift cards for select retailers.

1 To view your rewards, open the Sydney Health app or go to **anthem.com/ca**. Next, go to *My Health Dashboard*.

2 Select **My Rewards**.

3 Select **Redeem Rewards** to see how much you've earned. Use your rewards toward electronic gift cards from popular retailers, including Amazon, Uber, Gap Options (all brands), Apple, Target, The Home Depot, and TJ Maxx. The minimum gift card amount is set by each individual retailer.



Download the Sydney Health mobile app by scanning this QR code with your phone's camera.

Do you have questions?

Log in at **anthem.com/ca** or open the Sydney Health app. Then go to *My Health Dashboard* and select **My Rewards** to learn more. You can also call Member Services at the number on your ID card.

LIFE & AD&D COVERAGE

Basic Life and AD&D Coverage

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

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

This benefit will reduce by 35% at age 65 and 50% at age 70.

Voluntary Life and AD&D Coverage

As an employee of Le Lycée Français de Los Angeles, you have the option of purchasing additional life and AD&D coverage through The Standard. This voluntary policy enables you to purchase coverage for yourself and qualified dependents. When you enroll yourself and your dependents in this benefit, you pay the full cost through post-tax payroll deductions. Please note that elections made for Life coverage must match AD&D elections.

New Hires: If you apply for coverage that is above the Guaranteed Issue Amount, or if you are applying for coverage after 31 days after you become eligible, you must fill out a Medical Evidence of Insurability (EOI) form.
Current Employees:If you previously waived coverage, all benefit amounts are subject to full medical underwriting/EOI. All dependent child benefits are guaranteed issue.

	Employee	Spouse/DP	Child(ren)*
Coverage Option	Increments $10,000	Increments of $5,000	Increments of $5,000
Guarantee Issue Amount	$100,000	$25,000	All Amounts
Maximum Amount	The lesser of $300,000 or 5x annual earnings	$150,000; not to exceed 50% of the employee's benefit amount	$10,000; not to exceed 50% of the employee's benefit amount

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



Employee Assistance Program
Service Summary
Large Group - California

Anthem

Available 24/7, 365 days a year

Everything you share is confidential*

Life can be full of challenges. Your Anthem Employee Assistance Program (EAP) is here to help you and your household members. EAP offers a wide range of **no-cost** support services and resources, including:

Counseling
- Up to 3 visits per issue
- In-person or online visits
- Call EAP or use the online Member Center to initiate services

Legal consultation
- 30-minute phone or in-person meeting
- Discounted fees to retain a lawyer
- Free legal resources, forms, and seminars online

Financial consultation
- Phone meeting with financial professionals
- Regular business hours; no appointment required
- Free financial resources and budgeting tools online

ID recovery
- Help reporting to consumer credit agencies
- Assistance with paperwork and creditor negotiations

Dependent care and daily living resources
- Online information about child care, adoption, elder care, and assisted living
- Phone consultation with a work-life specialist
- Help with pet sitting, moving, and other common needs

Other anthemEAP.com resources
- Well-being articles, podcasts, and monthly webinars
- Self-assessment tools for emotional health issues

Crisis consultation
- Toll-free emergency number; 24/7 support
- Online critical event support during crises

We are ready to support you

You can call us at **800-999-7222**, or go to **anthemEAP.com** and enter your company code: Anthem California

When something unexpected happens, EAP can help you figure out your next steps. Contact us today.

* In accordance with federal and state law, and professional ethical standards.
This document is for general informational purposes. Check with your employer for specific information on the services available to you.

Language Access Services – (TTY/TDD: 711)
Spanish – Tiene el derecho de obtener esta información y ayuda en su idioma sin costo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.
Chinese – 您有權免費獲得該資料和協助。請使用您的 ID 卡上的成員服務電話號碼。

Anthem complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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VOLUNTARY BENEFITS

Voluntary Products

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



Critical Illness Coverage

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

Voluntary Benefit Amounts:

- **Employee: Increments of $5,000 up to $50,000**
- **Spouse/Domestic Partner: Increments of $2,500 up to $25,000; not to exceed 50% of Employee Benefit Amount**
- **Dependent Child(ren): Increments of $2,500 up to $5,000; not to exceed 50% of Employee Benefit Amount**

Pay Out Examples:

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

Accident Coverage

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

Coverage Amounts:

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

Coverage Pay Out Examples:

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

PerkSpot | IMA

Make every dollar count with your employee discount program.

Exclusive deals on everyday essentials to big-ticket buys.





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Access deals in 25+ categories—like groceries, travel, electronics, and more—allowing you to stretch your dollars further.



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LE LYCÉE FRANÇAIS DE LOS ANGELES

Advocating for Your Benefits Support Needs

Discover How Charlie Can Help You Today!



Charlie's personalized benefits support provides a team of dedicated advocates to help you and your covered family members maximize your benefits, alleviating the overwhelming process of navigating the complex world of employee benefits.

A Line of Support at Your Fingertips

At Charlie, our team of licensed experts are available to answer benefit questions you may have, from:

+ Medical, Dental and Vision
+ Voluntary Benefits, Life & Disability
+ HSAs, FSAs & EAPs
+ And more!

Our Benefits Experts

+ Explain the value and functionality of your benefits
+ Help locate in-network providers
+ Navigate your billing issues and assist in resolving insurance claims
+ Facilitate your pre-authorizations and support appeal options

...and other benefits-related concerns!

ASK Charlie

LE LYCÉE FRANÇAIS DE LOS ANGELES

Let us help!

Ask Charlie Advocacy Center

M-F 8AM to 6PM CST

EMAIL: **LeLycee.Benefits@imacorp.com**

PHONE: **833.548.7557**

PROVIDED BY IMA

IMACORP.COM/BENEFITS

This material is for general information only and should not be considered as a substitute for legal, medical, tax and/or actuarial advice. Contact the appropriate professional counsel for such matters. These materials are not exhaustive and are subject to possible changes in applicable laws, rules, and regulations and their interpretations.
NPN 1316541 | IMA, Inc dba IMA Insurance Services | California Lic #0H64724

EMPLOYEE CONTRIBUTIONS

	Monthly Payroll Deductions			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical				
Anthem Premier Vivity HMO	$214.58	$1,303.85	$938.03	$2,122.32
Anthem Value Select HMO	$216.05	$1,274.70	$919.19	$2,070.15
Anthem Value California Care HMO	$516.45	$1,922.80	$1,454.00	$2,996.74
Anthem Classic PPO	$974.97	$2,954.28	$2,284.71	$4,447.97
Dental & Vision				
Anthem Dental HMO	$3.43	$17.12	$19.18	$36.58
Anthem Dental PPO	$55.61	$124.13	$152.43	$233.12
Anthem Vision	$0	$5.90	$7.33	$14.91
Life				
Anthem EAP Resource Advisor	$0	$0	$0	$0
The Standard Basic Life AD&D	$0	N/A	N/A	N/A
The Standard Life AD&D	Rates in ADP	Rates in ADP	Rates in ADP	Rates in ADP
Voluntary Benefits				
Sun Life Voluntary Critical Illness	Rates in ADP	Rates in ADP	Rates in ADP	Rates in ADP
Sun Life Voluntary Accident Insurance	$17.55	$25.63	$29.32	$37.40

Please note: All benefit elections are processed in ADP.
Please see Human Resources with any questions related to cost or accessing ADP.

Carrier Contact Information

Administrator	Benefit	Phone	Website
Anthem Blue Cross	EAP/Resource Advisor	(888) 209-7840	www.resourceadvisor.anthem.com
Anthem Blue Cross	Medical HMO	(855) 383-7248	www.anthem.com/ca
Anthem Blue Cross	Medical HMO - Vivity Concierge	(855) 383-7248	www.vivityhealth.com
Anthem Blue Cross	Medical PPO	(855) 383-7248	www.anthem.com/ca
Anthem Blue Cross	Dental HMO	(800) 627-0004	www.anthem.com/ca
Anthem Blue Cross	Dental PPO	(877) 567-1804	www.anthem.com/ca
Anthem Blue Cross	Vision	(866) 723-0515	www.anthem.com/ca
The Standard	Life/AD&D	(800) 552-2137	lifeclaims@anthem.com
Ask Charlie Team	Ask Charlie Advocacy Team	(833) 548-7557	LeLycee.Benefits@imacorp.com
Sun Life	Accident & Critical Illness	(800) 247-6875	www.mysunlifebenefits.com

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

Notice: Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, see the contact information at the end of these notices.

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

Notice: HIPAA Notice of Privacy Practice

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It also describes how your protected health information may be used or disclosed to carry out treatment, payment or healthcare operation or for any purposes that are permitted or required by law.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement and other government requests
- Respond to lawsuits and legal action

Your Rights

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

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request.
- We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 9.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

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

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

Example: *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: *We use health information about you to develop better services for you.*

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: *We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your Plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: Your Rights Under HIPAA | HHS.gov.

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

Our Responsibilities

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

For more information see: Your Rights Under HIPAA | HHS.gov.

Notice: Consolidated Omnibus Budget Reconciliation Act (COBRA)

Introduction

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

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Continuation Coverage Available?

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

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

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

How is COBRA Continuation Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

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

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

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

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

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

Notice (APPLICABLE TO HMO GROUP HEALTH PLANS AND ALL FULLY-INSURED GROUP HEALTH PLANS IN OREGON): Patient Protection –Primary Care Designation

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

Notice (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): Patient Protection –Obstetrics & Gynecological care (HMO)

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

Notice (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): Patient Protection –Obstetrics & Gynecological care (HMO)

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

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, www.healthcare.gov.
If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial (877) KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored Plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call (866) 444-EBSA(3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2025. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
WEBSITE: http://www.myalhipp.com PHONE: (855) 692-5447	THE AK HEALTH INSURANCE PREMIUM PAYMENT PROGRAM WEBSITE: http://myakhipp.com/ PHONE: (866) 251-4861 EMAIL: CustomerService@MyAKHIPP.com MEDICAID ELIGIBILITY: WEBSITE: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid	CALIFORNIA – MEDICAID
WEBSITE: http://myarhipp.com/ PHONE: (855) MyARHIPP (855-692-7447)	WEBSITE: HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM http://dhcs.ca.gov/hipp PHONE: (916) 445-8322 Fax: (916) 440-5676 EMAIL: hipp@dhcs.ca.gov
COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)	**FLORIDA – MEDICAID**
HEALTH FIRST COLORADO WEBSITE: HTTPS://HEALTHFIRSTCOLORADO.COM/ HEALTH FIRST COLORADO MEMBER CONTACT CENTER: (800) 221-3943 / STATE RELAY 711 CHP+: HTTPS://HCPF.COLORADO.GOV/CHILD-HEALTH-PLAN-PLUS CHP+ CUSTOMER SERVICE: (800) 359-1991 / STATE RELAY 711 HEALTH INSURANCE BUY-IN PROGRAM (HIBI): HTTPS://WWW.MYCOHIBI.COM/ HIBI CUSTOMER SERVICE: (855) 692-6442	WEBSITE: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html PHONE: (877) 357-3268
GEORGIA – MEDICAID	**INDIANA – MEDICAID**
GA HIPP WEBSITE: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp PHONE: (678) 564-1162, PRESS 1 GA CHIPRA WEBSITE: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra PHONE: (678) 564-1162, Press 2	HEALTHY INSURANCE PREMIUM PAYMENT PROGRAM ALL OTHER MEDICAID WEBSITE: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ FAMILY AND SOCIAL SERVICES ADMINISTRATION PHONE: (800) 403-0864 MEMBER SERVICES PHONE: (800) 457-4584
IOWA – MEDICAID AND CHIP (HAWKI)	**KANSAS – MEDICAID**
MEDICAID WEBSITE: Iowa Medicaid | Health & Human Services PHONE: (800) 338-8366 HAWKI WEBSITE: Hawki - Healthy and Well Kids in Iowa | Health & Human Services PHONE: (800) 257-8563 HIPP WEBSITE: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) PHONE: (888) 346-9562	WEBSITE: https://www.kancare.ks.gov/ PHONE: (800) 792-4884 HIPP PHONE: (800) 967-4660
KENTUCKY – MEDICAID	**LOUISIANA – MEDICAID**
KENTUCKY INTEGRATED HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (KI-HIPP) WEBSITE: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx PHONE: (855) 459-6328 EMAIL: KIHIPP.PROGRAM@ky.gov KCHIP WEBSITE: https://kynect.ky.gov PHONE: (877) 524-4718 KENTUCKY MEDICAID WEBSITE: https://chfs.ky.gov/agencies/dms	WEBSITE: www.medicaid.la.gov or www.ldh.la.gov/lahipp MEDICAID HOTLINE: (888) 342-6207 LAHIPP PHONE: (855) 618-5488
MAINE – MEDICAID	**MASSACHUSETTS – MEDICAID AND CHIP**
ENROLLMENT WEBSITE: https://www.mymaineconnection.gov/benefits/s/?language=en_US PHONE: (800) 442-6003 TTY: Maine Relay 711 PRIVATE HEALTH INSURANCE PREMIUM WEBPAGE: https://www.maine.gov/dhhs/ofi/applications-forms PHONE: (800) 977-6740 TTY: Maine Relay 711	WEBSITE: https://www.mass.gov/masshealth/pa PHONE: (800) 862-4840 TTY: 711 EMAIL: masspremassistance@accenture.com

MINNESOTA – MEDICAID	MISSOURI – MEDICAID
WEBSITE: https://mn.gov/dhs/health-care-coverage/ PHONE: (800) 657-3739	WEBSITE: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm PHONE: (573) 751-2005
MONTANA – MEDICAID	**NEBRASKA – MEDICAID**
WEBSITE: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP PHONE: (800) 694-3084 EMAIL: HHSHIPPProgram@mt.gov	WEBSITE: http://www.ACCESSNebraska.ne.gov PHONE: (855) 632-7633 LINCOLN: (402) 473-7000 OMAHA: (402) 595-1178
NEVADA – MEDICAID	**NEW HAMPSHIRE – MEDICAID**
WEBSITE: https://dhcfp.nv.gov/ PHONE: (800) 992-0900	WEBSITE: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program PHONE: (603) 271-5218 TOLL FREE NUMBER FOR THE HIPP PROGRAM: (800) 852-3345 Ext. 15218 EMAIL: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – MEDICAID AND CHIP	**NEW YORK – MEDICAID**
MEDICAID WEBSITE: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ MEDICAID PHONE: (800) 356-1561 CHIP PREMIUM ASSISTANCE PHONE: (609) 631-2392 CHIP WEBSITE: http://www.njfamilycare.org/index.html CHIP PHONE: (800) 701-0710 TTY: 711	WEBSITE: https://www.health.ny.gov/health_care/medicaid/ PHONE: (800) 541-2831
NORTH CAROLINA – MEDICAID	**NORTH DAKOTA – MEDICAID**
WEBSITE: https://medicaid.ncdhhs.gov/ PHONE: (919) 855-4100	WEBSITE: https://www.hhs.nd.gov/healthcare PHONE: (844) 854-4825
OKLAHOMA – MEDICAID AND CHIP	**OREGON – MEDICAID**
WEBSITE: http://www.insureoklahoma.org PHONE: (888) 365-3742	WEBSITE: http://healthcare.oregon.gov/Pages/index.aspx PHONE: (800) 699-9075
PENNSYLVANIA – MEDICAID	**RHODE ISLAND – MEDICAID AND CHIP**
WEBSITE: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html PHONE: (800) 692-7462 CHIP WEBSITE: Children's Health Insurance Program (CHIP) (pa.gov) PHONE: (800) 986-KIDS (5437)	WEBSITE: http://www.eohhs.ri.gov/ PHONE: (855) 697-4347 or (401) 462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – MEDICAID	**SOUTH DAKOTA - MEDICAID**
WEBSITE: https://www.scdhhs.gov PHONE: (888) 549-0820	WEBSITE: http://dss.sd.gov PHONE: (888) 828-0059
TEXAS – MEDICAID	**UTAH – MEDICAID AND CHIP**
WEBSITE: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services PHONE: (800) 440-0493	UTAH'S PREMIUM PARTNERSHIP FOR HEALTH INSURANCE (UPP) MEDICAID WEBSITE: https://medicaid.utah.gov/upp/ EMAIL: upp@utah.gov PHONE: (888) 222-2542 ADULT EXPANSION WEBSITE: https://medicaid.utah.gov/expansion/ UTAH MEDICAID BUYOUT PROGRAM WEBSITE: https://medicaid.utah.gov/buyout-program/ CHIP WEBSITE: http://health.utah.gov/chip

VERMONT– MEDICAID	VIRGINIA – MEDICAID AND CHIP
WEBSITE: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access PHONE: (800) 250-8427	WEBSITE: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs MEDICAID & CHIP PHONE: (800) 432-5924
WASHINGTON – MEDICAID	**WEST VIRGINIA – MEDICAID AND CHIP**
WEBSITE: https://www.hca.wa.gov/ PHONE: (800) 562-3022	WEBSITE: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ MEDICAID PHONE: (304) 558-1700 CHIP TOLL-FREE PHONE: (855) MyWVHIPP (699-8447)
WISCONSIN – MEDICAID AND CHIP	**WYOMING – MEDICAID**
WEBSITE: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm PHONE: (800) 362-3002	WEBSITE: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ PHONE: (800) 251-1269

To see if any other States have added a premium assistance program since July 31, 2025, or for more information on *Special Enrollment Rights*, contact either:

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

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

OMB Control Number 1210-0137 (Expires: 1/31/2026)

Changes to the Terms of this Notice

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

For more information, contact:

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

Effective date of this Notice
January 1, 2025


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