

BENEFITS

2022

INFORMATION GUIDE

UNDERSTANDING YOUR OPTIONS














Hello!



Welcome to your 2022 Benefits Plan Year. PPOSBC is proud to offer a range of employee benefit plans to help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool designed to familiarize you with the plans and programs you and your family can enroll in for the plan year. If you have any questions regarding your benefits, please contact Human Resources.

	Eligibility & Enrollment	3
	Medical	5
	Dental	12
	Vision	13
	Life & Disability	14
	Spending Accounts	17
	Employee Assistance Program	18
	Perks & More	19
	Retirement Options	24
	Costs, Directory, and Required Notices	25



Enrollment

Who Can Enroll?

If you are a full-time regular employee working a minimum of 30 hours per week or if you are a part-time employee working 20 – 29 hours per week, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) and/or eligible children up to age 26 or children of any age who are incapable of self-support due to a physical or mental disability.

When Does Coverage Begin?

Your enrollment choices remain in effect from July 1, 2022 through June 30, 2023. Benefits for eligible new hires will commence as outlined below:

Eligibility Date

The first day of the month following 30 days of active employment.
(you must enroll within 30 days of becoming eligible)

Once you are benefit eligible, you are automatically enrolled in benefits which are paid 100% by PPOSBC

Benefit Plan

- Medical
- Dental
- Vision
- Voluntary Life / AD&D
- FSA
- Unum Supplemental Insurance
- Pet Insurance / Discount Program
- Legal/Identity Protection Plans
- Basic Life / AD&D
- Long-Term Disability
- Employee Assistance Program
- Prosper Wise Financial Wellbeing



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

What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's/registered domestic partner's loss or gain of coverage through our organization or another employer.
- An employee (1) is expected to average at least 30 hours of service per week, (2) has a change in status where he/she will reasonably be expected to average less than 30 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage).
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents.

Do I Have to Enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to \$0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. To waive coverage, you must select the "Decline Coverage" option in PlanSource. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be open enrollment for the following plan year or if a qualifying status change occurs.



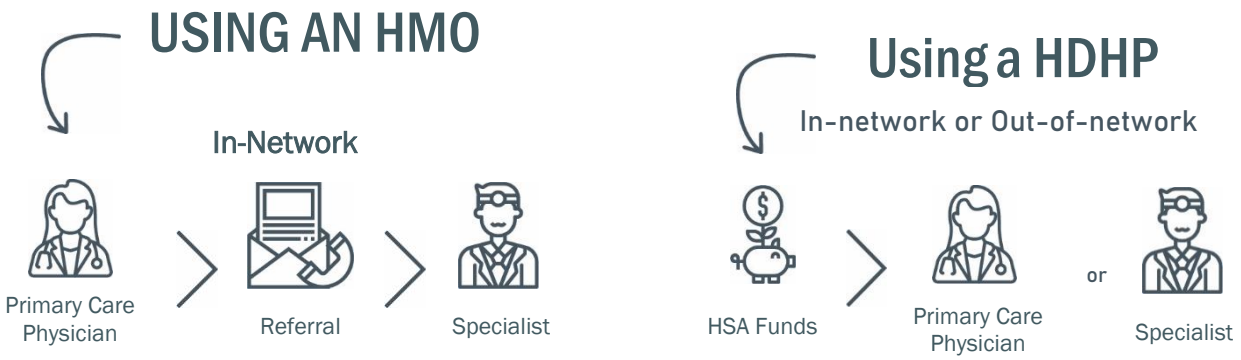
Medical

What are my Options?

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

	HMO Plans	HDHP Plan
	Anthem HMO Plans	Anthem HDHP
Required to select and use a Primary Care Physician (PCP)	Yes	No
Seeing a Specialist	PCP referral required in most cases	No referral required
Deductible Required	No	Yes
Claims Process	Usually handled by providers	PPO network providers will submit claims. You submit claims for other services.
Out-of-State Coverage	California Only	National coverage
Other Important Tips	<p>This plan requires that you see a doctor in a specific network to receive coverage</p> <p>Out-of-Network services without proper PCP referral will not be covered</p> <p>Emergencies covered worldwide</p>	<ul style="list-style-type: none"> Although this plan has a higher deductible than most plans, it comes with a Health Savings Account. The HSA account provides a tax-favored vehicle to help you manage your out-of-pocket expenses. Emergencies covered worldwide.

Please note the above examples are used for general illustrative purposes only. Please consult with your Human Resources Department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit www.anthem.com/ca.



Prescription Drug Coverage

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

- The Anthem plans cover generic formulary, brand-name formulary, non-formulary brand, and specialty drugs.
- Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
- A brand-name medication is protected by a patent and can only be produced by one specified manufacturer.
- Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list.
- Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

For a current version of the prescription drug list, go to www.anthem.com/ca.

WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:



Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk-in pharmacy.



Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.



Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.

TIP

Medical Services Covered in Full

The federal Health Care Reform law now requires insurance companies to cover preventive care services in full, saving you money and helping you maintain your health. Preventive services may include annual check-ups, well-baby and child visits and certain immunizations and screenings.

To confirm that your preventive care services are covered, refer to your plan documents.

Anthem Plan Highlights

Anthem HMO (Full & Select Network)

	In-network Only
Annual Calendar Year Deductible	
Individual	None
Family	None
Plan Year Out-of-Pocket Maximum (Resets 1/1)	
Individual	\$2,500
Family	\$5,000
Professional Services	
Preventive Care Services	No charge
Primary Care Physician (PCP) Visit	\$30 copay
Specialist Visit	\$50 copay
Telehealth Visit (LiveHealth Online)	\$30 copay for PCP \$50 copay for Specialist
Diagnostic X-ray and Lab	No charge
Complex Diagnostics (MRI/CT Scan)	\$100 copay per test
Chiropractic Care (20 visits per year)	\$30 copay
Acupuncture (20 visits per year)	\$30 copay
Physical, Occupational and Speech Therapy (40 visits per year)	Office: \$30 copay Outpatient Hospital: \$50 copay
Hospital Services	
Inpatient Hospitalization	\$500 copay per day (Up to 3 days max per admission)
Outpatient Surgery	\$250 copay
Emergency Room Visit	\$150 copay (waived if admitted)
Urgent Care Visit	\$30 copay
Mental Health & Substance Abuse	
Inpatient Hospitalization	\$500 copay per day (Up to 3 days max per admission)
Outpatient	\$30 copay
Retail Prescription Drugs (30-day supply)	
Generic	\$15 copay
Preferred Brand	\$30 copay
Non-Preferred Brand	\$50 copay
Specialty	\$50 copay
Mail Order Prescription Drugs (90-day supply)	
Generic	\$30 copay
Preferred Brand	\$60 copay
Non-Preferred Brand	\$100 copay
Specialty	N/A

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of plan benefits, limitations and exclusions

Full Network = Blue Cross HMO (CA Care) Limited Network = Select HMO

Anthem Plan Highlights

Anthem HDHP HSA

	In-network	Out-of-network
Annual Calendar Year Deductible (Reset 1/1)¹		
Individual	\$1,500	\$4,500
Family	\$2,800 per member / \$3,000 family	\$4,500 per member / \$9,000 family
Calendar Year Out-of-Pocket Maximum (Resets 1/1)	<i>Includes Deductible</i>	
Individual	\$3,000	\$9,000
Family	\$3,000 per member / \$6,000 family	\$9,000 per member / \$18,000 family
Professional Services		
Preventive Care Services	No Charge	40% after deductible
Primary Care Physician (PCP) Visit	20% after deductible	40% after deductible
Specialist Visit	20% after deductible	40% after deductible
Telehealth Visit (LiveHealth Online)	No charge after deductible for PCP 20% after deductible for Specialist	No charge after deductible for PCP 20% after deductible for Specialist
Diagnostic X-ray and Lab	20% after deductible	40% after deductible
Complex Diagnostics (MRI/CT Scan)	20% after deductible	40% after deductible
Chiropractic Care (30 visits per year)	20% after deductible	40% after deductible
Acupuncture (20 visits per year)	20% after deductible	40% after deductible
Physical and Occupational Therapy (40 visits per year) Speech Therapy (20 visits per year)	20% after deductible	40% after deductible
Hospital Services		
Inpatient Hospitalization	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Emergency Room Visit	20% after deductible (waived if admitted)	
Urgent Care Visit	20% after deductible	40% after deductible
Mental Health & Substance Abuse		
Inpatient Hospitalization	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Retail Prescription Drugs (30-day supply)	<i>Deductible Applies</i>	
Tier 1a	\$5 copay	40% coinsurance after deductible (up to \$250 per prescription)
Tier 1b	\$15 copay	40% coinsurance after deductible (up to \$250 per prescription)
Tier 2	\$40 copay	40% coinsurance after deductible (up to \$250 per prescription)
Tier 3	\$60 copay	40% coinsurance after deductible (up to \$250 per prescription)
Tier 4	30% coinsurance after deductible (up to \$250 per prescription)	40% coinsurance after deductible (up to \$250 per prescription)
Mail Order Prescription Drugs (90-day supply)	<i>Deductible Applies</i>	
Tier 1a	\$12.50 copay	
Tier 1b	\$37.50 copay	
Tier 2	\$120 copay	Not Covered
Tier 3	\$180 copay	
Tier 4	30% coinsurance after deductible (up to \$250 per prescription)	

1. Plan deductible contributes towards the out of pocket maximum

Health Savings Account (HSA)

What is it?

By enrolling in the Anthem High Deductible Health Plan (HDHP), you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses.

- The monthly HSA banking administration fee is paid for by PPOSBC

What are the benefits?

Administered by Anthem, an HSA accumulates funds that can be used to pay current and future health care costs.

- You can contribute to your HSA on a pre-tax basis, for federal tax purposes, or you can contribute on a post-tax basis and take the deduction on your tax return.
- Generally, HSA funds can grow on a tax-free basis, subject to state law.¹
- An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified health care expenses (tax regulations vary by state).
- Because you own the HSA, there are no “Use it or Lose it” provisions, so unused HSA funds roll over from year-to-year, and can be used to reimburse future eligible out-of-pocket expenses.
- Because you own the HSA, the money in your account is yours to keep if you leave the company.
- PPOSBC contributes \$600 to your HSA for employee-only coverage, and \$1200 for an employee covering dependents.
- The PPOSBC HSA contribution is prorated based on date of hire

How do I qualify for an HSA?

The IRS has guidelines regarding who qualifies for an HSA. You are considered eligible if:

- You are covered under a qualified LTD plan.
- You are not enrolled in non-qualified health insurance outside of PPOSBC's HSA PPO plan.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else's tax return (excluding a spouse).
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA).

A few rules you need to know:

- For 2022, the maximum contribution limit for employee and employer contributions in an employee's HSA account is \$3,650 if you are enrolled in the HSA-PPO for employee-only coverage, and \$7,300 for employees with dependent coverage.
- For 2023, the maximum contribution limit for employee and employer contributions in an employee's HSA account will increase to \$3,850 if you are enrolled in the HSA-PPO for employee-only coverage, and to \$7,750 for employees with dependent coverage.
- It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit <http://anthem.com/ca/qme>.
- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses.
- You may not contribute to your HSA if you are covered under any medical benefits plan which is not an HSA-qualified high deductible medical plan (e.g., a spouse's non-HDHP medical plan, a general purpose Health Care FSA, or Medicare). However, you may be covered by a Limited Purpose Health Care FSA, or an FSA which can be used after your HDHP deductible is met.
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a **pro-rated** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, under the full contribution rule, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1 of the first year and continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year).

How do I get started?

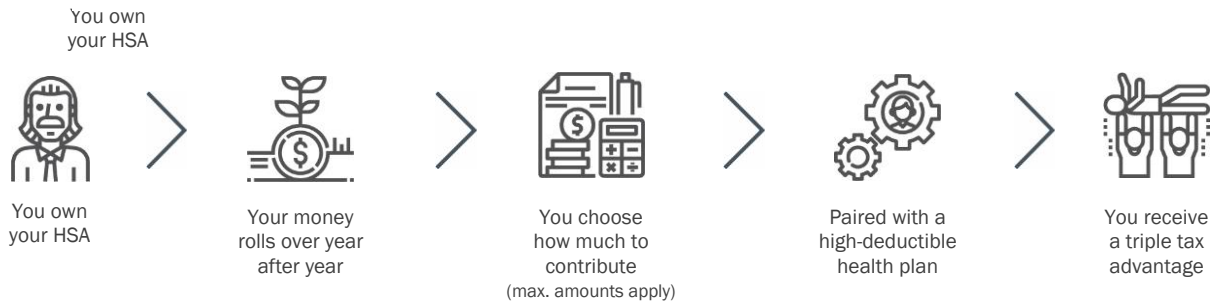
Here's how to use your HSA:

- Add money to your HSA anytime or contributing through paycheck deductions.
- Look out for your debit card in the mail.
- Use your HSA debit card to pay for doctor visits, prescriptions, and other qualified medical expenses.

Once the HSA is activated, you can manage and access your account at any time by visiting www.anthem.com/ca/ca. If questions arise regarding account activation, contact Anthem or visit www.anthem.com/ca/ca. Consult your tax advisor for taxation information or advice.

⁽⁴⁾ Please consult your tax advisor for applicable tax laws in your state.

WHAT TO KNOW ABOUT YOUR HEALTH SAVINGS ACCOUNT



Benefits Information on the Go

Use Anthem's mobile app, Sydney, when you're on the go!

Through Sydney, you can:

- Find a doctor, hospital or urgent care facility.
- View your personal benefits information through the Health Dashboard.
- View and use digital ID cards.
- Use the chatbot and get answers quickly.

Search for Sydney in the App Store or Google Play to get started!



Anthem LiveHealth Online!

With Anthem LiveHealth Online, you can:

- Access an online doctor visit using two-way video and secure instant messaging.
- Receive care for colds, the flu, allergies, and minor infections.
- Avoid scheduling an appointment or sitting in waiting rooms.
- Save yourself time and money.
- Access registered physicians 24/7/365.

Get started now at livehealthonline.com!



Telehealth Services

Anthem provides access to **two** telehealth services as part of your medical plan – **LiveHealth Online** and **24/7 NurseLine**

Anthem Telehealth Services let you get the care you need – including most prescriptions (when appropriate) – for a wide range of minor conditions. Now you can connect with a board-certified doctor via video chat, without leaving your home or office. When, where and how it works best for you!

Say it's the middle of the night and your child is sick. Or you're at work and not feeling well. If you pre-register with LiveHealth Online you can speak with a doctor for help with:

- | | |
|-----------------|-----------------------|
| • Sore throats | • Acne |
| • Headaches | • Rashes |
| • Stomachaches | • Shingles |
| • Fever | • Bronchitis |
| • Colds and flu | • Urinary tract |
| • Allergies | • Infections and more |

LiveHealthOnline.com

888.548.3432

24/7 NurseLine

800.337.4770

Signing up is Easy!

- Visit livehealthonline.com or download the free LiveHealth Online app on your mobile device

24/7 NurseLine

Whether it's 3 a.m. or a lazy Sunday afternoon, you can talk to a registered nurse any time of the day or night. These nurses can:

- Answer questions about health concerns.
- Help you decide where to go for care when your doctor, dentist, or eye doctor isn't available.
- Help you find providers and specialists in your area.
- Enroll you and your dependents in health management programs.
- Remind you about scheduling important screenings and exams, including dental and vision checkups.

Get the support you need. Call 800.337.4770

Dental Plan

Your Dental HMO & PPO Plan

You and your eligible dependents have the opportunity to enroll in either a Dental Health Maintenance Organization (HMO) plan or a Dental Preferred Provider Organization (PPO) plan offered through Anthem. We encourage you to review the coverage details and select the option that best suits your needs.

Using the Plan

In order to receive benefits while enrolled in the **Dental HMO plan**, you and your enrolled eligible dependents must obtain services from a primary care dentist who participates in the Anthem network. If you receive services from a provider outside of the approved network, you will be responsible for the entire dental bill.

The **Dental PPO plan** is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind; you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

Anthem Plan Highlights	Dental HMO (Plan 3000B)	Dental PPO	
	In-Network Only	In Network	Out of Network
Annual Calendar Year Deductible ¹ Individual / Family	N/A	\$50 / \$150	\$50 / \$150
Annual Calendar Year Maximum ¹ Per member	N/A	\$2,000	\$1,500
Services		You Pay	You Pay ²
Preventive	Services covered at scheduled copays	0% deductible waived	0% deductible waived
Basic		10% after deductible	20% after deductible
Major		40% after deductible	50% after deductible
Orthodontia ³			
Pre-orthodontic treatment visit	Included		
Child(ren)	\$1,695	Child to age 26 ONLY - 50% up to \$1,500 no deductible	
Adult	\$1,895		
Banding (per type of banding)	\$350		
Orthodontic retention (retainers)	\$250		

1. Deductible and annual maximum reset 1/1 of every plan year
2. For out-of-network services, Anthem will reimburse according to reasonable and customary allowances but the dentist may balance bill up to their usual fees.
3. Additional fees may apply to the process of obtaining braces, please refer to the patient charge schedule listed on the Anthem dental HMO Plan Summary

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of plan benefits, limitations and exclusions.



Find your Favorite Dentist

To determine whether your dentist is in or out of your insurance network, go to www.anthem.com/ca and search the "Find Care", or call 800.627.0004 (HMO) / 844.729.1565 (PPO).

Vision Plan



Your Vision Plan

Vision coverage is offered through EyeMed as a Preferred Provider Organization (PPO) plan.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers. You will be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network provider, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

To view a complete plan summary, visit www.eyemedvisioncare.com.

Plan Highlights

EyeMed PPO

	In-Network	Out-of-Network
Exam - Every 12 months from service	\$10 Copay	Reimburse up to \$40
Lenses - Every 12 months from service		
Single	\$10 Copay	Reimburse up to \$30
Bifocal	\$10 Copay	Reimburse up to \$50
Trifocal	\$10 Copay	Reimburse up to \$70
Standard Progressive Lens	\$75 Copay	Reimburse up to \$50
Premium Progressive Lens (Tier 1 - Tier 4)	\$95 - 120 Copay	Reimburse up to \$50
Lenticular	\$10 Copay	Reimburse up to \$70
Frames - Every 24 months from service	\$0 Copay, \$130 allowance + 20% off remaining balance	Reimburse up to \$91
Contacts - Every 12 months from service, instead of glasses		
Medically Necessary	\$0 Copay, Paid-in-Full	Reimburse up to \$210
Disposable	\$0 Copay, \$130 allowance	Reimburse up to \$130
Conventional	\$0 Copay, \$130 allowance + 15% off remaining balance	Reimburse up to \$130

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of plan benefits, limitations and exclusions.

Basic Life and AD&D

Protect your loved ones

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Your coverage

Paid for in full by PPOBC, the benefits outlined below are provided by New York Life:

- Basic Life / AD&D Insurance of 2x annual earnings up to \$500,000 maximum

IRS Regulation: Employees can receive employer paid life insurance up to \$50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of \$50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- You can change your beneficiary designation at any time
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated
- To select or change your beneficiary, contact Human Resources

State & Long Term Disability

Added protection

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings.

Your Plans

Coverage Details

State Disability Insurance

- The state you reside in may provide a partial wage-replacement disability insurance plan
- For more information regarding statutory disability programs, contact Human Resources

Long Term Disability Coverage (LTD)

- If your disability extends beyond 90 days, the LTD coverage through New York Life can replace 60% of your monthly earnings, up to maximum of \$10,000 for hourly employees and up to a maximum of \$15,000 for salaried employees
- Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability

TIP

Disability Facts and Figures

- One in every seven people will become disabled for five years or more in their lifetime
- Nearly half (46%) of all foreclosures are caused by financial hardship due to a disability

Source: www.affordableinsuranceprotection.com/disability_facts

Tax considerations: Because disability is an employer-paid benefit and is available for employees at no cost, disability payments made to you will be taxable. Consult your tax advisor for additional taxation information or advice.

Voluntary Life and AD&D

If you would like to supplement your employer paid life insurance plan, additional Life and AD&D coverage for you and your dependents is available for purchase on a payroll deduction basis through New York Life.

- **For employees:** Increments of \$10,000 up to a maximum of \$500,000 or 5x annual salary whichever is lesser with a guarantee issue benefit of \$200,000, if you enroll in the plan within 30 days of your initial eligibility
- **For your spouse:** Increments of \$5,000 up to a \$150,000 maximum and must not exceed 50% of employee elected amount with a guarantee issue benefit of \$30,000, if you enroll in the plan within 30 days of your initial eligibility
- **For your child(ren):** 14 days old up to 6 months of age, \$250; 6 months old up to age 26 and unmarried, \$10,000

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts that are subject to review will not be effective until the insurance company approves.

If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65 and the reduction will become effective on policy's anniversary date. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Cost of Voluntary Life and AD&D

Age of Insured	Monthly Rate per \$5,000	Monthly Rate per \$10,000
Less than 20	\$0.19	\$0.38
20-24	\$0.25	\$0.50
25-29	\$0.30	\$0.59
30-34	\$0.30	\$0.59
35-39	\$0.36	\$0.72
40-44	\$0.50	\$1.00
45-49	\$0.75	\$1.50
50-54	\$1.15	\$2.30
55-59	\$1.97	\$3.94
60-64	\$3.03	\$6.05
65-69*	\$5.14	\$10.28
70-74	\$10.30	\$20.60
CHILD	\$10.30	\$20.60

PPOSBC's Catastrophic Leave Donation program

PPOSBC realizes that employees may have a family emergency or a personal crisis that causes a severe financial impact to them, resulting in a need for additional time off in excess of their available personal time. To address this need all eligible employees will be allowed to donate vacation time from their unused balance to their co-workers in need. This policy is strictly voluntary.

Any active employee is eligible to participate as a recipient in the Program after completing 6 months of continuous employment. Eligible employees are only able to receive donated time from the Leave Donation Program once in a rolling 12 month period.

To be eligible to receive donated time, the employee or their immediate family members must have a critical or catastrophic health condition or personal crisis, which requires they take time away from work. Immediate family members are defined as spouse, domestic partner, child, parent or other relationship in which the employee is the legal guardian or sole caretaker.

Critical or Catastrophic Health Condition

A critical or catastrophic health condition means an illness or injury that requires continued physicians care, as indicated by physician certification. This Program does not cover time off due to a job-incurred injury covered by workers compensation benefits.




Personal Crisis

A personal crisis is a major disaster that causes severe hardship to an employee or family member of an employee. Major disasters must be declared by the President of the United States to qualify as a personal crisis.

For additional information regarding the program and procedures please contact Human Resources.

Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
 Health Care FSA	<ul style="list-style-type: none">• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance.• Maximum contribution for 2022 is \$2,850.• Carryover Max \$570.
 Dependent Care FSA	<ul style="list-style-type: none">• Can be used to pay for a child's (up to the age of 14) child care expenses and/or care for a disabled family member in the household, who is unable to care for themselves.• Maximum contribution for 2022 is \$5,000.
 Limited Purpose FSA	<ul style="list-style-type: none">• Employees may want to consider a limited purpose FSA if they are HSA eligible and plan to contribute to an HSA during the plan year.• This FSA may be used to reimburse qualified preventive care, dental, and vision expenses.• Maximum contribution for 2022 is \$2,850.• Carryover will occur in 2023.

What are the benefits?

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

How do I use it?

You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment in the fall. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. You can make contribution changes anytime during the year without a Qualifying Life Event. Visit www.goigoe.com to access IGOE's online portal.

For more details about using an FSA, contact IGOE or Human Resources.

A few rules you need to know:

- Once you make an election for the year, you cannot change it unless you have a qualifying event.
- Your FSA benefit card is designed to work at stores where most of the items sold are eligible. You may be asked to "substantiate" a debit card purchase, if more information is needed by IGOE to ensure the purchase was an eligible expense.
- You may carryover up to \$570 from your 2022 Health FSA to the 2023 Plan Year.
- The carryover amount does not impact the following year's maximum contribution – you will still be permitted to contribute the plan maximum.
- During the 3-month run-out period, the new Plan Year pays first and carryover plan will pay second. Igoe will determine the amount of the carryover at the end of the run-out period – any leftover amounts above the carryover limit from the previous Plan Year will be forfeited.
- If you enroll in the Anthem HDHP, you will be eligible to participate in the Limited Purpose FSA. If you are currently enrolled in the Health Care FSA and decide to enroll in the Anthem HDHP, your Health Care FSA funds automatically rollover into a Limited Purpose FSA.

For more details about using an FSA, contact IGOE Customer Service at 800.633.8818 or visit <https://www.goigoe.com/contact.aspx> .



Employee Assistance Program (EAP)

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

Program Component

Coverage Details

Who Can Utilize

All employees, dependents of employees, and members of your household

Topics May Include

- Childcare
- Eldercare
- Legal services
- Identity theft
- Marital, relationship or family problems
- Bereavement or grief counseling
- Substance abuse and recovery
- Financial support
- Consumer information

Number of Sessions

3 face-to-face sessions per year per member per incident



How to Access – Available 24/7:

- **By Phone:** 800.383.1908
- **Online:** <https://www.vitalworklife.com/>
- **Username:** pposbceap
- **Password:** member



Anthem's LearntoLive Program



Change your mind. Change your life.

Log in to anthem.com/ca, go to **My Health Dashboard**, choose **Programs**, and select **Emotional Well-being Resources**.

A wealth of resources at your fingertips:

- Personalized, one-on-one coaching
- Build a support team
- Practice mindfulness on the go
- Live and on-demand webinars

Education Assistance Program

The Agency recognizes that continued education can have a positive impact on an employee's growth and development; therefore, we support and encourage staff to take advantage of educational opportunities to enhance their knowledge, skills and abilities.

The Agency will provide Education Assistance to eligible employees for the pursuit of a degree or a non-degree certification / license, through approved / accredited institutions of learning, that is relevant to their current position or that enhances their skillset as determined by the Agency.

Eligibility:

Eligibility is based on the following criteria:

- Employee must have completed one year of service with PPOSBC.
- Employee must be classified as regular full-time (40+ hours) or part-time (20-39 hours).
- Employee must be performing at a satisfactory level and NOT be on a documented Final Warning within six months preceding the application.
- Not applicable to employees classified as Per Diem or Temporary.
- Changes to employment status during the approval and/or course completion may impact the reimbursement amount eligibility.



ProsperWise

Powered by people and amplified by technology. ProsperWise includes a variety of comprehensive services tailored to your employee needs on a variety of topics:



Enrollment/
Transition



Investing
Basics



Intermediate
Investing



Pre-Retiree/
Life Stages



Budgeting/
Debt Management



Estate Planning
Basics



Voluntary
Benefits



Social Security/
Medicare



College
Planning



Retirement
Income Strategies

MMA Financial coaches will answer your employee's individual questions to help them reach their financial goals

- Unlimited On-Demand Virtual 1:1 Consultations with a Financial Coach
- Monthly Webinar Series
- Employee Financial Well-being Engagement Certification Program
- Interactive Financial Well-being Website and App
- Personalized Assessment Tools
- Student Loan Benefit Solutions

To Visit Prosperwise use:
<https://www.mmaprosperwise.com/>
 or QR Code



Continuation of Medical Education (CME):

The agency provides reimbursement for our licensed staff to maintain their state medical license. Please see CME Reimbursement Policy # 400-111.

Discount Perks:

Planned Parenthood Orange and San Bernardino Counties staff are eligible to take advantage of discounts on:

- Fun Express
 - Discount tickets for movies, theme parks, water parks and other family attractions
- Gym Discount

For more information on these perks and discounts can be found on the intranet **PP Connect>Document Center>Human Resources>Employee Discount**

Voluntary Pet Care

United Pet Care Discount Program

Nationwide Pet Insurance

Type of Benefit	A membership savings program	A health care insurance plan	
How It Works	When services are received from a participating veterinarian a discount of 20-50% is applied instantly to your bill. Discount amounts vary by covered services received.	Nationwide will reimburse up to 50 - 70% back on vet bills. A member pays the bill upfront and submits a claim for reimbursement via mail, email or a mobile app.	
Annual Deductible	n/a	\$250	
Maximum Annual Benefit	n/a	\$7,500	
Network of Veterinarians	Yes - member must choose a Primary Care Veterinarian that is part of United Pet Care's network	No, free to visit any licensed veterinarian	
Claim Forms	No	Yes	
Pre-existing Conditions Excluded	No	Yes	
	Available Plans	Available Plans	
Available Plans	Preferred	My Pet Protection with Wellness	My Pet Protection
	Employee Savings (%)	Plan pays up to 50 - 70% of the bill for the below services	
Office Visits/Annual Exams	25-50%		
Vaccinations	25-50%	√	
Surgeries/Hospitalization	20-25%	√	√
Diagnostic Testing/Lab Work	20-25%	√	
Allergies/Infections	20-25%	√	√
Radiology	20-25%	√	√
Medications	20-25%	√	√
Spay/Neuter	20-25%	√	

The above is not a complete list of covered services and additional limitations/exclusions may apply



United Pet Care Veterinary Savings Program

For questions please email info@unitedpetcare.com or contact United Pet Care at 949.916.7374 or 888.781.6622.

If you enroll in the Pet Care Veterinary Savings Program, it is a one year membership. However, you do not have to continue to be enrolled in the program if you no longer have a pet, you are no longer an employee at PPOSBC or if you move out of the service area for this plan.

Nationwide Pet Insurance



Visit www.petinsurance.com/pposbc or call 877.738.7874 for more information or to get a no-obligation quote.

Voluntary Supplemental Insurance

Unum Critical Illness Coverage

This policy will pay cash to help families with the expenses associated with life-threatening diseases, debilitating illness, and injuries. Benefits may be paid for initial diagnosis, hospital stays, doctor visits, physical therapy, home health care, nursing home care, and possibly more. Some of the covered medical conditions may include:

- Heart attack
- Stroke
- Coma or paralysis
- Kidney failure
- Organ transplant
- Severe burns

Unum Short Term Disability

Can you support yourself or your family on State Disability alone? Unum's Short-Term Disability pays cash to you to help with lost income due to an injury, illness or pregnancy. This plan helps you take care of your every-day bills while you're out of work.

Unum Accident Plan

Accidents happen when you least expect them and can include motor vehicle accidents, sports injuries, slips, falls or just every day mishaps! Unum's policy may pay cash to help families offset the expenses associated with accidents or injuries. Benefits may be paid for:

- Emergency room and doctor visit
- Follow up and physical therapy visits
- Hospital admission and confinement
- Ambulance
- Medical Equipment (crutches, leg braces, etc.)

Unum Hospital Insurance

Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth. Benefits may be paid for:

- Hospital Admission
- Hospital Daily Stay

For more information regarding cost and how to enroll, contact Human Resources.

ARAG – Legal Protection

ARAG is a voluntary benefit that covers a wide range of legal needs to help you address life's legal situations, such as:

- Consumer Protection (Auto repair, home improvement, small claims court, personal property disputes, etc.)
- Criminal Matters (Juvenile, parental responsibility)
- Debt Related Matters (Debt collection, garnishments, personal bankruptcy, student loan debt)
- Driving Matters (License suspension, traffic tickets)
- Tax Issues (IRS tax audit/collection)
- Family (Adoption, name change, divorce, etc.)
- Services for Tenants (Contracts/lease agreements, eviction, security deposit, etc.)
- Real Estate & Home Ownership (Buying a home, deeds, foreclosure, real estate disputes, etc.)
- Will & Estate Planning (Powers of attorney, trusts, wills)

Contact at 800.789.2720

<http://araglegal.com/myinfo>



Legal Insurance



Allstate – Identity Protection

Allstate Identity Protection is a voluntary benefit that goes beyond just identity protection. This plan gives you access to:

- Identity and credit monitoring
- High risk transaction monitoring
- Dark web monitoring
- Data breach notifications
- Social media monitoring
- Protect yourself and your family
- Remediation of pre-existing conditions at no additional cost
- Full service 24/7 fraud remediation with a highly trained in-house expert
- \$1 million identity theft insurance policy

Contact at 800.247.4184

<https://www.allstateidentityprotection.com/>

For more information regarding cost and how to enroll, contact Human Resources.



Retirement Program

PPOSBC Retirement 401(k) Plan Highlights

Eligibility:

Immediately eligible to start 401k employee contributions.

Matching, Safe Harbor and Profit Sharing:

You will begin receiving employer contributions after one year of service.

Enrollment:

You may enroll in the plan at any time after you begin working for PPOSBC.

Plan contributions:

You may contribute from 1% up to 100% of your pay, subject to a maximum of \$22,500 in 2023.

If you are age 50 or older, you may be able to contribute an additional \$7,500 in 2023 known as a catch-up contribution.

Your contributions will be automatically deducted from your paycheck before taxes are calculated.

You may make changes to your contribution deferral amount at any time.

Matching contributions:

50% of deferrals up to 6% of compensation deferred, 3% maximum match.

Safe-harbor non-elective:

3% of compensation, do not have to contribute to the plan to receive this contribution.

Profit sharing:

Discretionary 2% profit sharing contribution. Must work 1000 hours and be employed on the last day of the plan year to receive the contribution.

Rollover:

You may roll over pre-tax money into this plan from a former employer's plan or from an IRA.

Plan distributions:

If you are over age 59 ½ you may request an in-service distribution from your 401(k) Deferral Account, Matching, Safe Harbor and Profit Sharing Accounts.

You may withdraw any portion of your Rollover Contribution Account at any time while you are still employed.

Your entire vested account balance is payable to you upon retirement, termination of employment, disability, or death (payable to your beneficiary).

Participant loans:

You will be permitted to borrow from the Plan, including the money you have rolled over. The minimum amount you can request is \$1,000, and the maximum available is the lesser of \$50,000 or 50% of your vested account balance. You may only have one loan outstanding at a time.

Vesting schedule:

You are always 100% vested in your 401(k) Deferral, Safe Harbor, and Rollover contribution accounts. Matching and Profit Sharing accounts will vest 25% a year after the second year of employment. 100% vested after 5 years for those hired after 6/30/2011

Investment changes:

You can change the investment of your accounts at any time.

You can change the investment of your future contributions at any time.

You may change your investments either by calling the automated voice response system at (877) 410-9984 plan provider number is 6789, or online at www.yourplanaccess.net/nwps/

Account statements:

Your account statement is issued quarterly, shortly after the end of each calendar quarter.

Your account statement includes your account balance, contribution amounts, distributions, and any investment gains or losses that occurred during the reporting period.

TIP

Questions About Your Retirement Plan?

Experts are available to help you:

- Evaluate your progress with retirement goals
- Determine how much you should be saving
- Decide which investment choices are best for you

NFP Customer service representatives are ready to help

- 800-959-0071, ext. 227 | retirementinfo@nfp.com

Marsh & McLennan Agency LLC does not serve as advisor, broker-dealer or registered investment advisor for this plan. All of the terms and conditions of your plan are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Costs, Directory, and Required Notices

Cost Breakdown

The rates below are effective July 1, 2022 – June 30, 2023



Coverage Level	Full-time (30+ Hours)		
	Employee Per Pay Period Cost (26)	Employee Monthly Cost	Employer Monthly Cost
Anthem Medical HMO – Select Network			
Employee Only	\$11.04	\$23.93	\$493.74
Employee and Spouse/ RDP	\$194.32	\$421.02	\$717.87
Employee and Child(ren)	\$19.88	\$43.07	\$888.74
Employee and Family	\$97.80	\$211.90	\$1,392.89
Anthem Medical HMO – Full Network			
Employee Only	\$33.34	\$72.23	\$493.74
Employee and Spouse/ RDP	\$243.36	\$527.27	\$717.87
Employee and Child(ren)	\$60.00	\$130.01	\$888.74
Employee and Family	\$166.90	\$361.62	\$1,392.89
Anthem HDHP HSA			
Employee Only	\$67.96	\$147.25	\$441.75
Employee and Spouse/ RDP	\$358.84	\$777.48	\$518.32
Employee and Child(ren)	\$146.80	\$318.06	\$742.15
Employee and Family	\$252.82	\$547.77	\$1,278.12
Anthem Dental HMO			
Employee Only	\$0.54	\$1.16	\$10.62
Employee and Spouse/ RDP	\$5.23	\$11.34	\$12.22
Employee and Child(ren)	\$5.66	\$12.27	\$13.06
Employee and Family	\$8.19	\$17.74	\$22.55
Anthem Dental PPO			
Employee Only	\$15.34	\$33.23	\$26.59
Employee and Spouse/ RDP	\$30.67	\$66.45	\$53.18
Employee and Child(ren)	\$33.40	\$72.37	\$57.88
Employee and Family	\$51.15	\$110.83	\$88.66
EyeMed Vision PPO			
Employee Only	\$1.30	\$2.82	\$2.82
Employee and Spouse/ RDP	\$2.47	\$5.36	\$5.37
Employee and Child(ren)	\$2.60	\$5.64	\$5.65
Employee and Family	\$3.83	\$8.30	\$8.30

*RDP: Registered Domestic Partner

Cost Breakdown



The rates below are effective July 1, 2022 – June 30, 2023

Coverage Level

Part-time (20-29 Hours)

	Employee Per Pay Period Cost (26)	Employee Monthly Cost	Employer Monthly Cost
Anthem Medical HMO – Select Network			
Employee Only	\$68.01	\$147.36	\$370.31
Employee and Spouse/ RDP	\$277.15	\$600.49	\$538.40
Employee and Child(ren)	\$122.42	\$265.25	\$666.56
Employee and Family	\$258.52	\$560.12	\$1,044.67
Anthem Medical HMO – Full Network			
Employee Only	\$90.30	\$195.66	\$370.31
Employee and Spouse/ RDP	\$326.19	\$706.74	\$538.40
Employee and Child(ren)	\$162.55	\$352.19	\$666.56
Employee and Family	\$327.62	\$709.84	\$1,044.67
Anthem HDHP HSA			
Employee Only	\$118.93	\$257.69	\$331.31
Employee and Spouse/ RDP	\$418.64	\$907.06	\$388.74
Employee and Child(ren)	\$232.43	\$503.60	\$556.61
Employee and Family	\$400.29	\$867.30	\$958.59
Anthem Dental HMO			
Employee Only	\$3.03	\$6.57	\$5.21
Employee and Spouse/ RDP	\$8.00	\$17.33	\$6.23
Employee and Child(ren)	\$8.65	\$18.75	\$6.58
Employee and Family	\$12.52	\$27.12	\$13.17
Anthem Dental PPO			
Employee Only	\$23.01	\$49.85	\$9.97
Employee and Spouse/ RDP	\$46.01	\$99.68	\$19.95
Employee and Child(ren)	\$50.10	\$108.56	\$21.69
Employee and Family	\$76.73	\$166.24	\$33.25
EyeMed Vision PPO			
Employee Only	\$1.95	\$4.23	\$1.41
Employee and Spouse/ RDP	\$3.72	\$8.05	\$2.68
Employee and Child(ren)	\$3.91	\$8.47	\$2.82
Employee and Family	\$5.75	\$12.45	\$4.15

*RDP: Registered Domestic Partner

Directory & Resources

Below, please find important contact information and resources for PPOSBC.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources: • Christina Gusman, Benefits Specialist		714.633.6373 ext. 369	Christina.Gusman@PPOSBC.org
Medical Coverage			
Anthem			
• Anthem HMO Full Network	L02861H004	833.913.2236	www.anthem.com/ca
• Anthem HMO Select Network	L02861H007	833.913.2236	
• Anthem HDHP Single	L02861M004	800.888.8288	
• Anthem HDHP Family	L02861M007	800.888.8288	
Dental Coverage			
Anthem			
• Dental Net	L028610001	800.627.0004	www.anthem.com/ca
• Essential Choice Dental Complete	L028610003	844.729.1565	
Vision Coverage			
EyeMed			
• PPO	1001185	866.939.3633	www.eyemedvisioncare.com
Life, AD&D and Disability			
New York Life			
• Basic & Voluntary Life	FLX965356	800.362.4462	www.newyorklife.com
• Basic & Voluntary AD&D	OK966941		
• Long Term Disability	LK963720		
Flexible Spending Accounts			
IGOE		800.633.8818	www.goigoe.com
Employee Assistance Plan			
Vital WorkLife		800.383.1908	https://www.vitalworklife.com/ code: PPOSBC
Prosper Wise		212.345.5000	https://www.mmaprosperwise.com/
Voluntary Supplemental Insurance			
Unum		800.635.5597	www.unum.com
ARAG		800.247.4184	www.ARAGlegal.com/myinfo Access Code: 18924pp
AllState ID Protection		800.247.4184	https://www.allstateidentityprotection.com/

Pet Insurance			
United Pet Care Veterinary Savings Program	1197	949.916.7374 888.781.6622	info@unitedpetcare.com
Nationwide Pet Insurance	7443	877.738.7874	www.petinsurance.com/pposbc
401(k)			
Fidelity NFP	6789	877.835.5097 800.959.0071 ext. 227	www.netbenefits.com retirementinfo@nfp.com

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

All rights reserved. No part of this document may be reproduced or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission of Marsh & McLennan Insurance Agency LLC.

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Medicare Part D notice

Important Notice from PPOSBC About Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Anthem and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PPOSBC has determined that the prescription drug coverage offered by the Anthem is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

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

If you decide to join a Medicare drug plan while enrolled in PPOSBC coverage as an active employee, please note that if your PPOSBC coverage is subject to the Medicare Secondary Payer rules, the PPOSBC will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced if your PPOSBC coverage is subject to the Medicare Secondary Payer rules, which applies to all employers with 20 or more employees. Medicare will usually pay primary for your prescription drug benefits if you participate in PPOSBC coverage as an individual who loses eligibility under the plan (e.g., termination, reduction in hours).

You may also choose to drop your PPOSBC coverage. If you do decide to join a Medicare drug plan and drop your current PPOSBC coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with PPOSBC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through PPOSBC changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	May 6, 2022
Name of Entity/Sender:	Ellie Ghotbi
Contact-Position/Office:	VP, Human Resources
Address:	801 E. Katella
Phone Number:	Anaheim, CA 92805

Legal Information Regarding Your Plans

REQUIRED NOTICES

Women's Health & Cancer Rights Act

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

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

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

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

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

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

Special Enrollment Rights

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

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

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

"HIPAA Special Enrollment Opportunities" include:

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

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

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

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

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

13. 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:

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

Grandfathered Plans

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

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

Prohibition on Excess waiting Periods

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

Preexisting Condition Exclusion

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

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

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

⁽¹⁾ Indicates that this event is also a qualified "Change in Status"

⁽²⁾ Indicates this event is also a HIPAA Special Enrollment Right

⁽³⁾ Indicates that this event is also a COBRA Qualifying Event

CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

What is COBRA continuation coverage?

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

15. Your hours of employment are reduced, or
16. 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:

17. Your spouse dies;
18. Your spouse's hours of employment are reduced;
19. Your spouse's employment ends for any reason other than his or her gross misconduct;
20. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
21. 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:

22. The parent-employee dies;
23. The parent-employee's hours of employment are reduced;
24. The parent-employee's employment ends for any reason other than his or her gross misconduct;
25. The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
26. The parents become divorced or legally separated; or
27. 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:

28. The end of employment or reduction of hours of employment;
29. Death of the employee;
30. Commencement of a proceeding in bankruptcy with respect to the employer; or
31. 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 after the qualifying event occurs. You must provide this notice to: lgoe Services

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

How is COBRA continuation coverage provided? (Continued)

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period ⁽¹⁾ to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Ellie Ghotbi
VP, Human Resources
801 E. Katella Ave

Anaheim, CA 92805 For More Information

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

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

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

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

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

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

(1) <https://www.medicare.gov/sign-up-change-plans/how-to-1-get-part-a-b/part-a-part-b-sign-up-period>

Military Family Leave Entitlements

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

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

Benefits & Protections

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

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

Eligibility Requirements

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

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

⁽²⁾ Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

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

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

Use of Leave

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

Substitution of Paid Leave for Unpaid Leave

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

Employee Responsibilities

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

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

Employer Responsibilities

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

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

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

38. Interfere with, restrain, or deny the exercise of any right provided under FMLA;

39. 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) TTY: (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:

40. You are absent from work due to service in the uniformed services (defined below);

41. You were covered under the Plan at the time your absence from work began; and

42. You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

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

What Happens if You do not Elect to Continue Coverage?

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

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

Premium for Continuing Your Coverage

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

Length of Time Coverage Can Be Continued

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

43. A premium is not paid in full within the required time;

44. 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

45. You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

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

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

Definitions

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

46. "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency

47. "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

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

This notice is EFFECTIVE: 7/1/2022

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

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

Required by Law

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

Permitted Plan use of Your Health Information

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights Regarding Your Health Information

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

52. Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
53. Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
54. Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
55. Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication

and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.

56. Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
57. 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.
58. Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.
59. Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
60. 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.
61. Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.
62. Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Plan Responsibilities

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

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

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

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint

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

Changes to the Terms of This Notice

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

Contact Person

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

Ellie Ghotbi
VP, Human Resources
801 E. Katella Ave
Anaheim, CA 92805

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

<p>ALABAMA – Medicaid</p> <p>Website: http://myalhipp.com/ Phone: 1-855-692-5447</p>	<p>COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)</p> <p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442</p>
<p>ALASKA – Medicaid</p> <p>The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</p>	<p>FLORIDA – Medicaid</p> <p>Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268</p>
<p>ARKANSAS – Medicaid</p> <p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p>GEORGIA – Medicaid</p> <p>Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131</p>
<p>CALIFORNIA – Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov</p>	<p>INDIANA – Medicaid</p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584</p>
<p>IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p>MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
<p>KANSAS – Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884</p>	<p>NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p>KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p>NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900</p>
<p>LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
<p>MAINE – Medicaid</p> <p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711</p>	<p>NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.nifamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p>MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840</p>	<p>NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p>MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p>NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>
<p>MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p>NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalsev/medicaid/ Phone: 1-844-854-4825</p>

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

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

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

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

Paperwork Reduction Act Statement

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

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

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

