HIGH TECH HIGH

Benefits Information Guide

2023

Guidelines/Evidence of Coverage

The benefit summaries listed on the following 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.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 2 months, Federal law gives you more choices about your prescription drug coverage. Please see page 36 for more details.

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.

Discover Your Benefits

Let's explore your benefit plan options, programs and resources.

Eligibility & Enrollment

Eligibility & Enrollment

Time to answer some questions…

Who can enroll?

Salaried employees who have a contract for 50% or more full-time employment will be eligible until the end of the contract year, provided they complete their contract.

Non-salaried employees who are hired to work full-time on an on-going basis, will be offered the same benefit programs as the salaried employees who have a contract for 50% or more of full-time employment. Please see High Tech High Handbook for definition of Full-Time employee.

Long Term Substitute Teachers or Leave Replacement Staff that are employed on contract at 50% or more for 12 consecutive work weeks.

Eligible employees may also choose to enroll family members, including a legal spouse / registered domestic partner / unregistered domestic partner **(hereinafter referred to as "unregistered domestic partner")** and/or eligible children.

Please note: If you are enrolling an unregistered domestic partner, you will need to complete a Domestic Partner Affidavit, indicating your unregistered domestic partner is eligible and acknowledging that HTH's contribution toward the additional coverage for your unregistered domestic partner coverage is reported as taxable (i.e. "imputed income") to you.

When does coverage begin?

Full-time Active Employees: The first day of the month following employment (in an eligible category). You must enroll within 30 days of becoming eligible

Variable Hour Employees (VHE): Non-salaried variable hour employees who are considered to be a full-time equivalent employee as determined by the Affordable Care Act. You are eligible to enroll at the end of your Initial/Standard Measurement Period and Administrative Period (if applicable) if you successfully average 30 or more hours of service per week. If you are eligible and elect coverage, your coverage will be effective the day following the end of your applicable Administrative Period OR your coverage will be effective on the day following the end of your Measurement Period.

Your enrollment choices remain in effect through the end of the benefits plan year, (August 1, 2023 – July 31, 2024). If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status event during the plan year. Please check with your plan administrator and your Section 125 plan document on any applicable status change events that would allow you to make a mid-year election change.

How do I get started with my enrollment?

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- HTH benefit-eligible employees will be receiving an email from TalentED to enroll in Benefits 2023-2024.
- If you have questions when completing your enrollment forms, contact our Payroll Team in the Business Office (ecocina@hightechhigh.org).

What if my needs change during the year?

You are permitted to make changes to your benefits after the open enrollment period if you have a change in status event 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 status change 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 loss or gain of coverage through our organization or another employer.
- An employee (1) was expected to average at least 30 hours of service per week, (2) has a change in employment 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 due to open enrollment or special enrollment period, and coverage 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 status change events, please refer to the "High Tech High's Health and Welfare Benefits Annual Notice Packet" contents at the end of this guide. A Qualifying Life Event is not necessary to change dental plans mid-year.

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 from a State or Federal Health Insurance Exchange.

For information regarding Healthcare Reform and the Individual Mandate, please contact our Payroll Team in the Business Office or visit www.cms.gov/cciio. 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 and/or dental coverage if you have access to coverage through another plan. To waive coverage, you must complete the "Health Insurance Coverage – Waiver Statements form". It is important to note that if coverage if waived, the next opportunity to enroll in our group benefit plans would be on August 1, 2024 or if a qualifying status change occurs.

Medical

Medical

Which plan type is right for you?

	HMO	PPO	HMO
	Anthem	Anthem	Kaiser
Required to select and use a Primary Care Physician (PCP)	**Yes**	**No**	**Yes**
Seeing a Specialist	PCP referral required in most cases	No referral required	Kaiser referral required in most cases
Deductible Required	No	Yes, you must pay a deductible before the plan's coinsurance begins to pay	No
Claims Process	Usually handled by providers	Usually, handled by providers. You may receive a bill for you portion of services	Usually handled by Kaiser
Chiropractic Services	• Offered through American Specialty Health (ASH) • At the time of your visit, present your Anthem ID card and only pay your $20 Copay – make sure your provider participates in the ASH network! • ASH providers bill Anthem directly so you do not have to file a claim!	• Offered through American Specialty Health (ASH) • At the time of your visit, pay your $20 Copay (Calendar Year deductible is waived) • To save money, make sure your provider participates in the ASH network!	• Offered through American Specialty Health • At the time of your visit, present your Kaiser ID card and only pay your $15 Copay - make sure your provider participates in the ASH network!
Other Important Tips	• This plan requires that you see a doctor in a specific network to receive coverage • Out-of-Network services without proper PCP referral will not be covered • Emergencies covered worldwide	• You may choose in or out of network care, however in-network care provides you a higher level of benefit • Emergencies covered worldwide	• This plan requires that you see a doctor in Kaiser to receive coverage • Out-of-Network services without proper PCP referral will not be covered • Emergencies covered worldwide

Please note the above examples are used for general illustrative purposes only.
Please consult with the Payroll Team in the Business Office for more specific information as it relates to your specific plan.

How to Find a Provider

Before you go to the doctor or receive health care services, make sure your doctor, facility or specialist is participating in your carrier's network. Review the instructions below on how to complete a "provider search" for your specific plan.

Anthem HMO and PPO

1. Go to www.anthem.com/ca and select "**Find Care**" at the top right of the webpage
2. Click "**Basic search as a guest**"
3. Under *Select the type of plan or network*, select **"Medical Plan or Network," "California," "Medical (Employer-Sponsored)**" and choose one of the following, "**Priority Select HMO," "Select HMO," or "Prudent Buyer PPO/EPO"** based on plan chosen and click **"Continue"**
4. Enter your zip code/search criteria and click on **"Primary Care"**
5. Under **Key Filters** on the left side of the webpage, select "**Serve as PCP**", so you are only viewing Physicians that may serve as your Primary Care Physician (PCP)

Tip: Use the "Back to Find Care" arrow to avoid starting your search over

Please note, with the HMO plans all care must be received within your Medical Group, including Urgent Care. Contact your PCP or Medical Group to determine if an Urgent Care facility is contracted. Urgent Care received outside of your Medical Group, even if it is an Anthem in-network facility, will not be covered.

Kaiser HMO

1. Logon to www.kp.org
2. Click on the "**Doctors and Locations**" link on the top of the webpage
3. Under "Region" select "**California-Southern**"
4. Enter your zip code and desired travel distance. You may also click choose your Provider type you are seeking. Then click "**Search**"
5. Once the list of providers shows up you may then search by Specialty and Provider Type

Anthem's Mobile App – Sydney Health:

- Find a doctor, hospital or other in network providers
- Login to view your personal benefits information
- See claims
- View and use digital cards
- Use the interactive chat feature and get answers quickly

Search for Sydney Health in the App Store or Google Play or go to www.anthem.com/ca/register to get started! For additional help, call 1.866.755.2680.

Kaiser Permanente's Mobile App:

With the Kaiser Permanente app, you can easily:

- Find facilities and pharmacies near you
- Email your doctor's office or Member Services with nonurgent questions
- Schedule, view, and cancel routine appointments and see information about past visits
- Fill or refill most prescriptions, check the status of a prescription order, and see a list of all your medications
- View your medical history, including allergies and immunizations, ongoing health conditions, and most lab test results
- Access your digital membership card to check in for appointments, pick up prescriptions, and more

Search for Kaiser App in the App Store or Google Play and sign in or create your online account to get started!

Prescription Drug (Rx) Benefits

Many FDA-approved prescription medications are covered through the benefits program. Tiered prescription drug plans require varying levels of payment depending on the drug's tier.

Generic formulary (Tier 1): Generic drugs contain the same active ingredients as their brand-name counterparts but are less expensive.

Brand name medications (Tier 2): A brand-name medication can only be produced by one specified manufacturer and is proven to be the most effective in its class.

Non-formulary prescriptions (Tier 3): Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list. This is because there is an alternative proven to be just as effective and safe, but less costly. Ask your doctor or pharmacist for additional information regarding the generic option.

Specialty prescriptions (Tier 4): Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring. Many drugs on the Kaiser Tier 4 are "specialty" drugs used to treat complex, chronic conditions, and may require special storage or close monitoring.

Why pay more for prescriptions?

Use 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 from a walk-in pharmacy

Shop Around

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

Over-the-Counter Options

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

"I need specific medical care! How much does it cost?"

Plan Highlights	Anthem Priority Select and Select HMO	Kaiser HMO
	In-Network Only	In-Network Only
Annual Calendar Year Deductible		
Individual	None	None
Family	None	None
Maximum Calendar Year Out-of-pocket [1]		
Individual	$1,500	$1,500
Family	$3,000	$3,000
Professional Services		
Primary Care Physician (PCP)	$20 Copay	$20 Copay
Specialist	$20 Copay	$40 Copay
Preventive Care Exam	No Charge	No Charge
Well-baby Care	No Charge	No Charge
Diagnostic X-ray and Lab	No Charge	$10 Copay
Complex Diagnostics (MRI / CT Scan)	$100 Copay	$150 Copay
Therapy, including Physical, Occupational and Speech	$20 Copay	$20 Copay
Chiropractic / Acupuncture	$10 Copay (30-visit combined Chiro / Acupuncture maximum)	$15 Copay Chiro Only (30-visit maximum)
Hospital Services		
Inpatient	No Charge	No Charge
Outpatient Surgery	No Charge	$40 Copay per Procedure
Emergency Room (copay waived if admitted)	$100 Copay	$250 Copay
Urgent Care (within/outside of area)	$20 Copay	$20 Copay
Maternity Care		
Physician Services (prenatal or postnatal)	No Charge	No Charge
Hospital Services	No Charge	No Charge
Mental Health		
Inpatient	No Charge	No Charge
Outpatient	No Charge	$20 Copay per Individual Visit
Substance Abuse		
Inpatient	No Charge	No Charge
Outpatient	No Charge	$20 Copay per Individual Visit
Retail Prescription Drugs	30-day supply	30-day supply
Contraceptive Drugs & Devices	No Charge	No Charge
Tier 1	$5 / $15 Copay	$10 Copay
Tier 2	$30 Copay	$30 Copay
Tier 3	$50 Copay	$30 Copay
Preferred Specialty Prescription	30% Coinsurance (up to $250/prescription)	30% Coinsurance (not to exceed $150)
Mail Order Prescription Drugs	90-day supply	100-day supply
Contraceptive Drugs & Devices	No Charge	No Charge
Tier 1	$12.50 / $37.50 Copay	$20 Copay
Tier 2	$90 Copay	$60 Copay
Tier 3	$150 Copay	$60 Copay
Preferred Specialty Prescription	30% Coinsurance (up to $250/prescription)	Not Covered

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

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

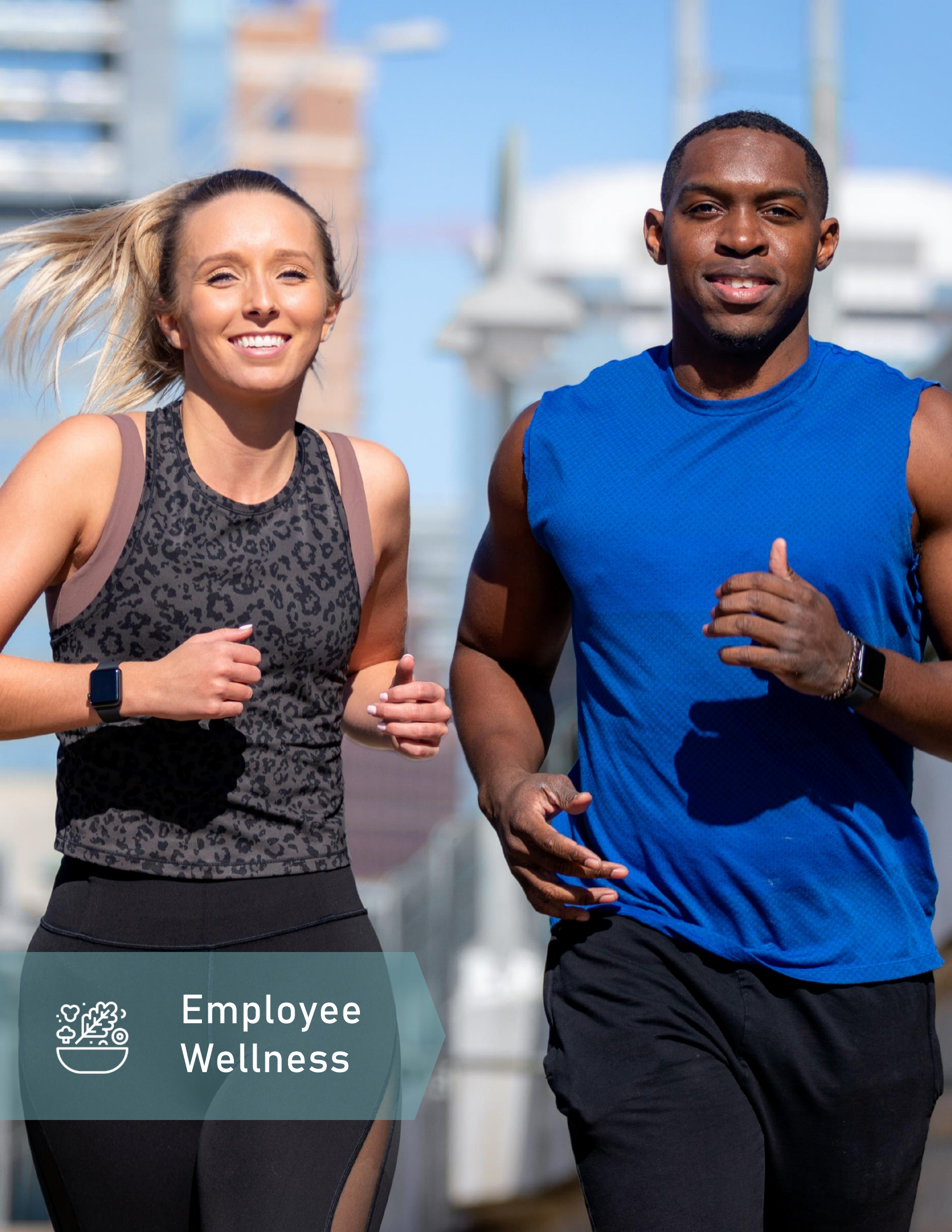
"I need specific medical care! How much does it cost?"

Plan Highlights	Anthem PPO	
	In-Network	Out-of-Network
Annual Calendar Year Deductible		
Individual	$250	$750
Family	$750	$2,250
Maximum Calendar Year Out-of-pocket (1)		
Individual	$2,500	$7,500
Family	$5,000	$15,000
Professional Services		
Primary Care Physician (PCP)	$20 Copay (deductible waived)	40% (after deductible)
Specialist	$40 Copay (deductible waived)	40% (after deductible)
Preventive Care Exam	No Charge	40% (after deductible)
Diagnostic Lab	20% (after deductible)	40% (after deductible)
Diagnostic X-Ray	20% (after deductible)	40% (after deductible)
Complex Diagnostics (MRI / CT Scan)	20% (after deductible)	40% (after deductible)
Chiropractic (30 visits max per year)	$20 Copay (deductible waived)	40% (after deductible)
Acupuncture (20 visits max per year)	$20 Copay (deductible waived)	40% (after deductible)
Therapy, including Physical, Occupational and Speech	20% (after deductible)	40% (after deductible)
Hospital Services		
Inpatient	20% (after deductible)	40% (after deductible)
Outpatient Surgery	20% (after deductible)	40% (after deductible)
Emergency Room (waived if admitted)	$150 Copay + 20% (after deductible)	
Urgent Care	$20 Copay (deductible waived)	40% (after deductible)
Maternity Care		
Physician Services (prenatal or postnatal)	No Charge	40% (after deductible)
Hospital Services	20% (after deductible)	40% (after deductible)
Mental Health & Substance Abuse		
Inpatient	20% (after deductible)	40% (after deductible)
Outpatient	20% (after deductible)	40% (after deductible)
Retail Prescription Drugs (30-day supply)		
Contraceptive Drugs & Devices	No Charge	No Charge
Tier 1	$5 / $15 Copay	50% Coinsurance (up to $250)
Tier 2	$30 Copay	50% Coinsurance (up to $250)
Tier 3	$50 Copay	50% Coinsurance (up to $250)
Preferred Specialty Prescription(2)	30% Coinsurance (up to $250/prescription)	50% Coinsurance (up to $250)
Mail Order Prescription Drugs (90-day supply)		
Contraceptive Drugs & Devices	No Charge	No Charge
Tier 1	$12.50 / $37.50 Copay	Not Covered
Tier 2	$90 Copay	Not Covered
Tier 3	$150 Copay	Not Covered
Preferred Specialty Prescription	30% Coinsurance (up to $250/prescription)	Not Covered

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

(2) If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network pharmacy charges and the amount Anthem would have paid for the same Prescription Drug product dispensed by a Non-Network pharmacy.

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


Employee
Wellness

Employee Wellness

A healthier you starts here – mind and body!

Why Wellness?

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual healthcare costs. We care about your total well-being and encourage all employees to engage in our wellness resources at no-cost.

Healthy Lifestyles Program

Kaiser Permanente invites you and your enrolled dependents to take an active role in improving your health with free, customized online programs designed to help you succeed in creating a healthier lifestyle. These programs are brought to you in collaboration with HealthMedia®, and focus on your total health—mind, body, and spirit. Fill out the online questionnaire at kp.org/healthylifestyles and receive your customized guide to a program that may include smoking cessation, nutrition, sleep, and stress.

Calm

Through Kaiser, you can access the Calm app at no-cost. Calm uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality. With guided meditations, programs taught by world-renowned experts, sleep stories narrated by celebrities, mindful movement videos, and more, Calm offers something for everyone. To get started, get the apps at www.kp.org/selfcareapps.

Learn to Live

Through Anthem, you and your enrolled dependents can access Learn to Live, an online program that supports emotional health and well-being at no cost. Learn to Live's personalized programs include interactive activities, daily health trackers to monitor and maintain your progress, in-the-moment coping tools, and more. It's designed to help you set goals and work towards them in ways that work for you – by making positive changes to support and work through your mental, emotional, and overall well-being. To get started, login to www.anthem.com, go to **My Health Dashboard**, choose "Programs", and select **Emotional Well-being Resources**.

Wellbeing Solutions

Through Anthem, members have access to the Wellbeing Solutions program. The Welling Solutions program connects you with easy-to-use digital health and wellness tools that can help you stay your best. Anthem's program uses a whole-person approach to build a clear picture of each member's health. The program offers a full suite of benefits with support for a wide variety of health goals.

Login to the Sydney Health app or www.anthem.com/member-resources/sydney-app to complete available activities, such as taking Health Assessment, participating in the well-being Coach Digital program and tracking your steps. Enrolled employees and their Spouses/Domestic Partners can earn up to $200 each for completing specific wellness activities.

Active and Fit Direct

For $28 a month, individuals are allowed to directly enroll in a “multi-fitness center” membership. Members have unlimited visits to any of the affiliated exercise centers and fitness clubs across the country (classes, trainers, pools, courts are not included). Members can select from over 11,000 fitness centers and access over 1,500 digital workout videos. One-on-one lifestyle coaching is available in areas such as fitness, nutrition, stress, and sleep.

To sign up for Active & Fit, participants must first register their Igoe Secure Web Portal Account. Instructions provided below. Once you have logged into your account, you simply need to scroll down to the below image on the lower right-hand side and click “Get Started.”

IGOE Online Registration

Go to www.goigoe.com. Click on the Participants tab and then click on the Sign In button. On the next page click the Register button.

Step 1 (Establish Your Login Credentials)

1. Enter the required registration information.
2. Enter your Registration ID: Ensure Employer ID Is selected from the dropdown and enter **IGOEHTH** in the field below.
3. Enter Employee ID: Your Employee ID is your **Social Security Number (without dashes).**
4. Accept Terms of Use and click the Next button.

Step 2 (Security Questions)

- Select 4 different security questions and supply answers to each of them.

Step 3 (Confirm Email)

- Confirm your email address.

Step 4 (Verify and Submit)

- Verify your information and make any necessary edits. Click Submit to register.

Your registration allows you to:

- Monitor your real time election and balance details
- Keep track of your spending timelines
- Securely enter claims and attach saved receipts or use Igoe Mobile to take photos of receipts and submit a claim
- Review transaction details
- Manage account communication options
- Report your Benefit Card lost/stolen
- Securely enter and update your Direct Deposit details
- Access eligible expense lists and more!

For questions, please contact Participant Services at 1 (800) 633-8818, option 1 or flex@goigoe.com.

Dental Plan

Dental Plan

A smile is the nicest thing you can wear.

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 Cigna network. If you receive services from a provider outside of the approved network, you would be responsible for paying the entire dental bill yourself.

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 will receive the highest level of benefits 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 an in-network PPO dentist.

To view complete plan summaries, please get them from the Payroll Team in the Business Office.

A Qualifying Life Event is necessary to change dental plans mid-year.

Find your Favorite Dentist

It is important to carefully select a dental provider, and based on the plan you enroll in, the best choice for you may vary. To determine whether your dentist is in or out of your insurance network, go to www.cigna.com and search the provider network, or call Cigna at 800.481.1213.

Plan highlights for both the Dental HMO and Dental PPO are included on the next page for your review and consideration.

"I need specific dental care! How much does it cost?"

Plan Highlights	Cigna Dental HMO	Cigna Dental PPO		
	In-Network Only	DPPO Advantage	Cigna DPPO	Out-of-Network
Calendar Year Deductible				
Per Person	None	$50	$50	$50
Family Maximum	None	$150	$150	$150
Services Excluded from Deductible	N/A	Preventive Services	Preventive Services	Preventive Services
Calendar Year Maximum	Unlimited	$1,500	$1,000	$1,000
Preventive				
Office Visit	$5 Copay	No Copay	20%	20%
X-rays	No Copay	No Copay	20%	20%
Cleanings	No Copay	No Copay	20%	20%
Sealants (per tooth)	No Copay	No Copay	20%	20%
Restorative				
Amalgam Fillings	No Copay	20% (1)	20% (1)	20% (1)
Composite Fillings	No Copay	20% (1)	20% (1)	20% (1)
Periodontics (gum treatment)				
Scaling & Root Planing	$30 - $50	20% (1)	20% (1)	20% (1)
Gingivectomy	$55 - $100 Copay	20% (1)	20% (1)	20% (1)
Endodontics (root canal therapy)				
Pulpotomy	$10 Copay	20% (1)	20% (1)	20% (1)
Root Canal (molar teeth)	$170 Copay	20% (1)	20% (1)	20% (1)
Oral Surgery				
General Anesthesia	$80 Copay (each 15 mins)	20% (1)	20% (1)	20% (1)
Simple Extraction	No Copay	20% (1)	20% (1)	20% (1)
Soft Tissue Impaction	$10 Copay	20% (1)	20% (1)	20% (1)
Complete or Partial Bony Impaction	$50 - $70 Copay	20% (1)	20% (1)	20% (1)
Crowns & Bridges				
Inlay / Onlay (2 surfaces)	$185 Copay	50% (1)	50% (1)	50% (1)
Crowns	$225 Copay	50% (1)	50% (1)	50% (1)
Prosthetics (dentures)				
Denture Adjustment	$20 Copay	50% (1)	50% (1)	50% (1)
Complete or Partial Denture	$275 - $325 Copay	50% (1)	50% (1)	50% (1)
Other				
Implant Prosthetics	$575 - $625 Copay	50% (1)	50% (1)	50% (1)
Implant Surgical Placement	Not Covered	Not Covered	Not Covered	Not Covered
Orthodontia Services				
Lifetime Max (per person)	N/A	$1,000	$1,000	$1,000
Adults	$1,992 Copay	Not Covered	Not Covered	Not Covered
Child(ren) up to Age 19	$1,512 Copay	50%	50%	50%

(1) Subject to Annual Deductible

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

Vision Plan

Vision Plan

Keep a clear focus on your sight.

Vision coverage is offered by Cigna as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit www.cigna.com.

"I need specific vision care! How much does it cost?"

Plan Highlights	Cigna Voluntary Vision PPO	
	In-Network	Out-of-Network
Exam – Every 12 months	$10 Copay	$45 Allowance
Lenses – Every 12 months		
Single	Covered 100% after $10 Copay	$32 Allowance
Bifocal	Covered 100% after $10 Copay	$55 Allowance
Trifocal	Covered 100% after $10 Copay	$65 Allowance
Lenticular	Covered 100% after $10 Copay	$80 Allowance
Frames – Every 24 months	$120 Allowance	$66 Allowance
Contacts – Every 12 months (in lieu of lenses & frames)		
Medically Necessary	Covered 100%	$210 Allowance
Cosmetic	$130 Allowance	$105 Allowance
Additional Pairs of Glasses	20% Savings	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.

Spending Accounts

Spending Accounts

Make your money work for you.

Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible healthcare 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
Healthcare FSA	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • Maximum contribution for 2023 is $2,750.
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Eligibility rules require that if you are married, your spouse needs to be working, looking for work or attending school full-time. • Maximum contribution for 2023 is $5,000.

How do I use it?

You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. 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. Visit www.goigoe.com to access Igoe's online portal. Under the participant tab, you can also find instructions on how to register for the Igoe Mobile App.

Please note IRS regulations require that a third-party review receipts for certain transaction as a way to making sure that these tax-free dollars are being used for approved expenses. At any time, you could receive a request from Igoe, as the third-party Administrators for High Tech High's FSA, to send in a receipt to validate the expense for a purchase made in your FSA Debit Card.

Should this occur, please remember to send all required documentation requested by Igoe to prevent potential disqualification of the expense and subsequent FSA Benefits Card deactivation.

Igoe representatives may be reached via email at flex@goigoe.com or by telephone at 800.633.8818, Option 1 from 8am – 5pm PST (Monday – Friday) should you have any questions.

A few rules you need to know:

- Your plan year runs from January 1, 2023 – December 31, 2023
- Your Flexible Spending Account allows for an annual run out period through March 31, 2024, allowing you to seek reimbursement for any expenses incurred during the plan year of January – December 2023. Any left-over amount after March 31, 2024 will be forfeited.

For more details about using an FSA, contact the Payroll Team in the Business Office (ecocina@hightechhigh.org).

Life & Disability

Life & Disability

Protection for your loved ones.

Basic Life and AD&D

In the event of your passing, 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 High Tech High, the benefits outlined below are provided by New York Life Group Benefit Solutions:

- Basic Life Insurance of 1x annual earnings up to $250,000
- AD&D of 1x annual earnings up to $250,000

Benefit Reduction Schedule - Benefits will reduce to 65% at age 65, 45% at age 70, 30% at age 75 and 20% at age 80.

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.

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional life and AD&D coverage for you and/or your dependents is available on a voluntary basis through payroll deductions from New York Life Group Benefits.

For employees:	Increments of $10,000 up to a $500,000 maximum 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 $10,000 up to a $250,000 maximum with a guarantee issue benefit of $30,000 if you enroll in the plan within 30 days of your initial eligibility. Spouse's rates are based on age of employee.
For your child(ren):	15 days old up to 6 months of age, Flat $500; 6 months old up to age 26, Increments of $5,000 up to a $10,000 maximum.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts 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. Benefit Levels and Guaranteed Issue Amounts are shown above.

Please note, if you are eligible for the Voluntary Life Insurance portion of this Policy but were not previously enrolled, you may become insured under the Policy for an amount equal to one Benefit Level without satisfying the Insurability Requirement. Such increases will become effective on the Policy Anniversary following the Re-enrollment Period.

Note: Benefits coverage may reduce when you reach age 65. 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 Coverage (Employee/ Spouse) 11-month Deductions

Age of Insured	Monthly Rate per $10,000
Less than 25	$0.65
25–29	$0.65
30–34	$0.87
35–39	$0.98
40–44	$1.53
45–49	$2.18
50–54	$3.27
55–59	$4.90
60–64	$7.20
65–69	$13.85
70–74	$22.47

Dependent Child Coverage

Benefit Amount	Monthly Premium*
$5,000	$0.98

One premium will insure all your eligible children, regardless of the number of children you have. Coverage is for dependent child to age if a full student.

Long Term Disability

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. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
State Disability Insurance	• The state you reside in may provide a partial wage-replacement disability insurance plan
Long Term Disability Coverage (LTD)	• If your disability extends beyond 90 days, the LTD coverage through New York Life Group Benefit Solutions can replace 60% of your earnings, up to maximum of $6,000 per month. • Your benefits may continue to be paid until you reach normal retirement age as long as you meet the definition of disability. • For more information regarding the statutory disability programs, contact the Payroll Team in the Business Office (payroll@hightechhigh.org).
STRS & PERS Disability Option	• STRS and PERS members may also qualify for disability retirement in case of catastrophic disability. • For more information on the STRS and PERS disability plans, please contact the Payroll Team in the Business Office (payroll@hightechhigh.org).

Tax considerations

Because disability coverage is an employer-paid benefit and is available for employees at no cost, any disability payments made to you will be taxable.

Life Assistance Program (LAP)

Employee Assistance & Wellness Support

Your free and confidential go-to resource.

High Tech High understands that you and your family members might experience a variety of personal or work-related challenges. This program offers counseling, legal and financial counseling, work-life assistance, well-being coaching, family care services, and crisis intervention services to covered employees and their household family members.

Program Component	Coverage Details
Number of sessions	3 face-to-face sessions per year per member per incident
How to access	Phone or face-to-face sessions
Topics may include	• Childcare • Eldercare • Legal and estate services • Identity theft • Marital, relationship or family problems • Bereavement or grief counseling • Survivor assurance for beneficiaries • Financial support • Secure travel assistance
Who can utilize	All employees, dependents of employees, and members of your household

Get in touch:

- By phone: 800.344.9752
- Online: www.guidanceresources.com (Web ID: NYLGBS)

Perks & More

Perks & More

Let's cover the fun stuff.

To round out your benefits package, we offer these additional perks to support both your personal and professional needs.

AFLAC Critical Illness Coverage

Offered by AFLAC, critical illness coverage is generally paid in the form of a one-time, lump sum payment, dependent on the illness. This will help reduce expenses associated with life-threatening diseases. Some of the covered medical conditions include:

- Cancer
- Heart attack
- Stroke
- Kidney failure
- Organ transplant

If you are considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For more information regarding cost and how to enroll, please contact the High Tech High Payroll Team in the Business Office.

AFLAC Accident Plan

Accidents happen when you least expect them and can include motor vehicle accidents, sports injuries, slips, falls or just everyday mishaps! AFLAC'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.)

If you are considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For more information regarding cost and how to enroll, please contact the High Tech High Payroll Team in the Business Office.

Pet Insurance

For many of us, our pets are just as special and loved as our family members. That's why it's important we protect their health too! Our pet insurance benefit, offered by Nationwide Pet Insurance, covers dogs, cats, birds, and some other exotic animals starting at $15 per month.

For more information, login to Nationwide's website at www.petinsurance.com/hightechhigh or contact them at 877.738.7874 to discuss the best care for your animal.

Costs, Directory, & Required Notices

Cost Breakdown

All of your rates in one place.

The rates below are effective August 1, 2023 – July 31, 2024.

Coverage Level	Total Monthly Premium (Based on 12 Months per Year)	High Tech High's Monthly Contribution (Based on 12 Months per Year)	Employee Cost Per Paycheck (Based on 22 Payroll Deductions per Year)
Anthem Select HMO			
Employee Only	$641.45	$641.45	$0.00
Employee and Spouse / Unregistered DP*	$1,411.19	$923.69	$265.91
Employee and Child(ren)	$1,154.61	$923.69	$125.96
Employee and Family	$1,988.50	$923.69	$580.81
Anthem Priority Select HMO			
Employee Only	$614.99	$614.99	$0.00
Employee and Spouse / Unregistered DP*	$1,352.98	$923.69	$234.16
Employee and Child(ren)	$1,106.98	$923.69	$99.98
Employee and Family	$1,906.47	$923.69	$536.07
Kaiser HMO			
Employee Only	$596.24	$596.24	$0.00
Employee and Spouse / Unregistered DP*	$1,430.98	$912.25	$282.95
Employee and Child(ren)	$1,073.23	$912.25	$87.81
Employee and Family	$1,848.35	$912.25	$510.60
Anthem PPO			
Employee Only	$876.28	$613.40	$143.39
Employee and Spouse / Unregistered DP*	$1,927.82	$923.69	$547.71
Employee and Child(ren)	$1,577.30	$923.69	$356.52
Employee and Family	$2,716.47	$923.69	$977.88
Cigna Dental - DHMO			
Employee Only	$13.13	$13.13	$0.00
Employee and Spouse / Unregistered DP*	$26.26	$21.01	$2.87
Employee and Child(ren)	$28.23	$22.58	$3.08
Employee and Family	$44.91	$35.93	$4.90
Cigna Dental - DPPO			
Employee Only	$34.51	$34.51	$0.00
Employee and Spouse / Unregistered DP*	$69.10	$55.28	$7.54
Employee and Child(ren)	$82.06	$65.64	$8.95
Employee and Family	$116.65	$93.33	$12.73
Cigna Vision PPO			
Employee Only	$7.80	$0.00	$4.25
Employee and Spouse / Unregistered DP*	$15.60	$0.00	$8.51
Employee and Child(ren)	$15.76	$0.00	$8.60
Employee and Family	$24.82	$0.00	$13.54

Directory & Resources

Below, please find important contact information and resources for High Tech High.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Senior Accountant and Benefits Analyst • Erika Cocina		P: 619.243.5004	ecocina@hightechhigh.org www.hightechhigh.org
Medical Coverage			
Anthem • Select HMO • Priority Select HMO • PPO	L08408H001 L08408H004 L08408M001	800.888.8288	www.anthem.com/ca
Kaiser • HMO	221062	800.464.4000	www.kp.org
Dental Coverage			
Cigna • DHMO & DPPO	3333484	800.244.6224	www.mycigna.com
Vision Coverage			
Cigna • Voluntary Vision	3333484	877.478.7557	www.mycigna.com
Life, AD&D and Disability			
New York Life • Life/AD&D • Voluntary Life • Long-Term Disability	FLX963529 / OK965163 FLX963529 LK962511	800.362.4462	www.cigna.com
Flexible Spending Accounts			
Igoe Administrators	High Tech High	800.633.8818 Opt. 1	www.goigoe.com
Employee Assistance & Wellness Support			
New York Life		800.344.9752	www.guidanceresources.com Web ID: NYLGBS
Pet Insurance			
Nationwide	High Tech High	877.738.7874	www.petinsurance.com/hightechhigh
Accident and Critical Illness			
Aflac		573.505.2129	www.aflac.com
Benefits Broker			
Marsh & McLennan Insurance Agency LLC 9171 Towne Centre Dr., Ste. 100 San Diego, CA 92122	Main Line	800.321.4696	www.MMA-West.com

High Tech High's Health and Welfare Benefits Annual Notice Packet

For the 2023 Plan Year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact us at:

High Tech High
Attention: Payroll Team - Business Office
2861 Womble Road,
San Diego, CA 92106
(619) 243-5000

Medicare Part D
Creditable Coverage Notice
Important Notice from High Tech High
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with High Tech High 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. **High Tech High has determined that the prescription drug coverage offered by the High Tech High 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 drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in High Tech High coverage as an igoe employee, please note that your High Tech High coverage 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 may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in High Tech High coverage as a former employee.

You may also choose to drop your High Tech High coverage. If you do decide to join a Medicare drug plan and drop your current High Tech High 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 High Tech High 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 High Tech High 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 Social Security on the web at www.socialsecurity.gov, or call them 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 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: 08/01/2023

Name of Entity/Sender: High Tech High
Contact--Position/Office: Payroll Team – Business Office

Address: 2861 Womble Road, San Diego, CA 92106
Phone Number: (619) 243-5000

HIPAA Special Enrollment Rights Notice

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

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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

High Tech High sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of High Tech High, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by High Tech High, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the High Tech High HIPAA Privacy Officer.

High Tech High
Attention: HIPAA Privacy Officer
Isaac Jones
ijones@hightechhigh.org
(619) 243-5015

Effective Date

This Notice as revised is effective August 1, 2023.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period High Tech High has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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 July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	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
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid

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

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx

Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

Website:

http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone:1-800-432-5924 CHIP Phone:1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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 July 31, 2022, 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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a 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. If you would like more information on WHCRA benefits, contact your plan administrator at 619.243.5000.

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

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

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Erika Cocina, Senior Accountant and Benefits Analyst.

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

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

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

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

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

- The month after your employment ends; or

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

- 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/agencies/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
High Tech High
Attention: Payroll Team - Business Office
2861 Womble Road,
San Diego, CA 92106
(619) 243-5000

APPENDIX

These are additional notices that may be appropriate based upon an employer's circumstances. We included the Surprise Billing Notice to assist with an employer's obligation to post the notice on its website.

- ☐ Medicare Part D Cross-Reference
- ☐ Medicare Part D Non-Creditable Coverage Notice
- ☐ HIPAA Privacy Notice of Availability
- ☐ HIPAA Wellness Program Reasonable Alternative Standards (RAS) Notice – Medical plans with wellness programs that offer health contingent incentives
- ☐ Surprise Billing Notice – "Your Rights and Protections Against Surprise Medical Bills"

Medicare Part D
Cross-Reference

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 35 for more details.

HIPAA Notice of Availability of
Notice of Privacy Practices

The High Tech High (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact:

High Tech High
Attention: Payroll Team - Business Office
2861 Womble Road,
San Diego, CA 92106
(619) 243-5000

HIPAA Wellness Program Reasonable
Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at (619) 243-5000 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Your Rights and Protections
Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This

amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

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