



2026 - 2027 BENEFITS GUIDE

EFFECTIVE JULY 1, 2026 – JUNE 30, 2027

INTRODUCTION

Welcome!

Orange County Academy of Sciences and Art recognizes the importance of having a comprehensive benefits program. Our program is designed to provide you and your family a variety of plans with tools that promote health and wellness. We are committed to making every effort to provide benefits that support the lifestyles and needs of our employees.

Benefit Options for 2026-2027

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

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

- Medical coverage through Anthem
- Medical coverage through Kaiser
- Dental coverage through Anthem
- Vision coverage through Anthem
- Flexible Spending Account services through Igoe
- Basic Life and AD&D coverage through Colonial Life - **New Carrier**
- Supplemental Life and AD&D coverage through Colonial Life - **New Carrier**
- Voluntary Short-Term Disability through Colonial Life
- Voluntary Accident, Critical Illness, and Hospital Indemnity coverage through Colonial Life

Please note:
Medicare
Creditable notice
can be located on
page 24.

CA Individual Mandate

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

When To Enroll

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

- When you are newly hired as a Orange County Academy of Sciences and Art employee. Your benefit coverage begins on the first of the month following 0 days after your hire date.
- During the annual benefits open enrollment period. See page 3.
- Within 30 days of a qualifying life event: See page 3 and contact Orange County Academy of Sciences and Art Human Resources Department for more information.

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



ELIGIBILITY

Open Enrollment

Open enrollment occurs one time each year. During this time, you may add or remove dependents from your coverage, change your coverage level, or change your benefit elections without experiencing a qualifying event. The benefits and coverage you select during this open enrollment period will remain in effect until June 30, 2027, unless you experience a qualifying life event and submit plan changes.



Eligibility

Employees:

Full-time employees working 30+ hours per week are eligible to participate in the Orange County Academy of Sciences and Art benefit plan.

Dependents:

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

Qualifying Events for Changing Benefits

If you waive coverage at this time, you cannot enroll in Orange County Academy of Sciences and Art. Health Plan until the next open enrollment period, unless you have a qualifying event. You have 30 days from the time of the qualifying event to notify Human Resources to change your benefits. Examples of qualifying events include:

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

INSURANCE BASICS

Medical HMO

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

Who should consider opting for a HMO?

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

Medical PPO

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

Who should consider opting for a PPO?

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

Dental HMO (DHMO)

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

Dental PPO (DPPO)

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



HOW TO FIND A PROVIDER

How To Find a Anthem Medical Provider

1. Go to www.anthem.com/ca
2. Click on Find Care located on the top right of the page
3. Click Basic search as a guest
4. Select the type of plan or network: Medical Plan or Network
5. Select the state where the plan or network is offered: California
6. Select how you get health insurance: Medical (Employer-Sponsored)
7. Select your plan or network.
8. Click Continue
9. Enter your Location
10. Select the type of Care Provider: Primary Care, Behavioral Health, Lab, Imaging, or Hospital
11. Relevant results will be displayed

How To Find a Kaiser Medical Provider

1. Visit kp.org
2. Click on "Doctors and Locations"
3. Select your location
4. Enter your search preference(s) and click "Search"
5. A list of providers will populate

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

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

Information about the PPO plan

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

Finding a Dentist:

1. Visit www.anthem.com/find-care
2. Click 'Select a plan for basic search' and then Dental Plan or Network
3. Enter your state and then select 'Dental'
4. Depending on which plan you choose, you will search by the applicable network:
 - a. Dental PPO
 - b. Dental HMO
5. You can search by provider name, geographic location, or specialty

Finding an Eye doctor:

1. Visit www.anthem.com/find-care
2. Click 'Select a plan for basic search' and then Vision Plan or Network
3. Enter your state and then select 'Vision'
4. Depending on which plan you choose, you will search by the applicable network:
 - a. Blue View Vision
5. You can search by provider name, geographic location, or specialty

MEDICAL COVERAGE: HMO OPTIONS

The following chart summarizes the benefits for the medical plans offered to all eligible employees of Orange County Academy of Sciences and Art. As an eligible employee, you may choose from one of the following plans.

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

	Anthem	Kaiser	Kaiser
	Gold Select HMO 35 903T	Gold 80 HMO 1000/40	Silver 70 HMO 2000/65
Annual Deductible Calendar year	None	\$1,000 Individual \$2,000 Family	\$2,000 Individual \$4,000 Family
Annual Out-of-Pocket Max Calendar year	\$6,750 Individual \$13,500 Family	\$8,200 Individual \$16,400 Family	\$8,900 Individual \$17,800 Family
Physicians Services			
Primary Care	\$35 Copay	\$40 Copay	\$65 Copay
Specialist Visits	\$70 Copay	\$60 Copay	\$100 Copay
Preventive Care	No Charge	No Charge	No Charge
Hospital Services			
Inpatient Hospitalization	\$750 Copay/day; Up to 4 days	\$600 Copay/day; Up to 5 days*	45%*
Outpatient Surgery	ASC: \$450 Copay; Outpatient Hospital: \$550 Copay	\$350 Copay*	45%*
Tests			
Advanced Imaging	\$250 Copay	\$350 Copay	\$400 Copay*
Diagnostic X-ray/Lab	\$15 Copay; Outpatient Hospital: Lab: \$30 Copay; X-ray: \$45 Copay	X-ray: \$60 Copay Lab: \$30 Copay	X-ray: \$75 Copay* Lab: \$35 Copay
Urgent / Emergency Care Visits			
Urgent Care	\$35 Copay	\$40 Copay	\$65 Copay
Emergency Room (Waived if admitted)	\$325 Copay	\$350 Copay	45%*
Prescriptions (Retail 30-day supply)			
Brand Name Rx Deductible	None	\$250 Individual / \$500 Family	Combined with medical deductible
Tier 1: Generic	Level 1: \$10 Copay Level 2: \$20 Copay	\$15 Copay	\$20 Copay
Tier 2: Preferred Brand Name	Level 1: \$50 Copay Level 2: \$60 Copay	\$50 Copay**	\$100 Copay
Tier 3: Non-Preferred Brand Name	Level 1: \$90 Copay Level 2: \$100 Copay	\$50 Copay**	\$100 Copay
Tier 4: Specialty/Specialty Drugs	Level 1: 30% up to \$250 Level 2: 40% up to \$250	20% up to \$250**	20% up to \$250*

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

* After Deductible
** After Rx Deductible

MEDICAL COVERAGE: PPO OPTION

The following chart summarizes the benefits for the medical plan offered to all eligible employees of Orange County Academy of Sciences and Art. As an eligible employee, you may choose to enroll in the following plan.

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

Anthem		
Gold PPO 35/500/25% 8V5C		
	In-Network	Out-of-Network
Annual Deductible Calendar Year	\$500 Individual \$1,500 Family	\$2,000 Individual \$4,000 Family
Annual Out-of-Pocket Max. Calendar Year	\$8,200 Individual \$16,400 Family	\$16,400 Individual \$32,800 Family
Physicians Services		
Primary Care	\$35 Copay	50%*
Specialist Visits	\$65 Copay	50%*
Preventive Care	No Charge	50%*
Hospital Services		
Inpatient Hospitalization	25%*	50% up to \$650/day*
Outpatient Surgery	ASC: \$50 Copay + 25%*; Outpatient Hospital: \$250 Copay + 25%*	ASC: 50%*; Outpatient Hospital: 50% up to \$380*
Tests		
Advanced Imaging	\$100 Copay + 25%*	50%*
Diagnostic X-ray/Lab	\$15 Copay*; Outpatient Hospital: 25%*	50%*
Urgent / Emergency Care Visits		
Urgent Care	\$35 Copay	50%*
Emergency Room (Waived if admitted)	\$250 Copay + 25%*	Same as In-Network
Prescriptions (Retail 30-day supply)		
Brand Name Rx Deductible	\$250 Individual / \$500 Family	N/A
Tier 1: Generic	Level 1: \$10 Copay Level 2: \$20 Copay	Not Covered
Tier 2: Preferred Brand Name	Level 1: \$50 Copay** Level 2: \$60 Copay**	Not Covered
Tier 3: Non-Preferred Brand Name	Level 1: \$90 Copay** Level 2: \$100 Copay**	Not Covered
Tier 4: Specialty/Specialty Drugs	Level 1: 30% up to \$250** Level 2: 40% up to \$250**	Not Covered

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

* After Deductible
** After Rx Deductible

FREQUENTLY ASKED QUESTIONS

What is a Deductible?

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

What is Coinsurance?

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

What is the Out-of-Pocket Maximum?

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

What is a Copay?

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

What is a Health Maintenance Organization (HMO)?

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

What is a Preferred Provider Organization (PPO)?

A PPO is a group of hospitals and physicians that contract on a fee-for-service basis with insurance companies to provide comprehensive medical service.

What is In-Network?

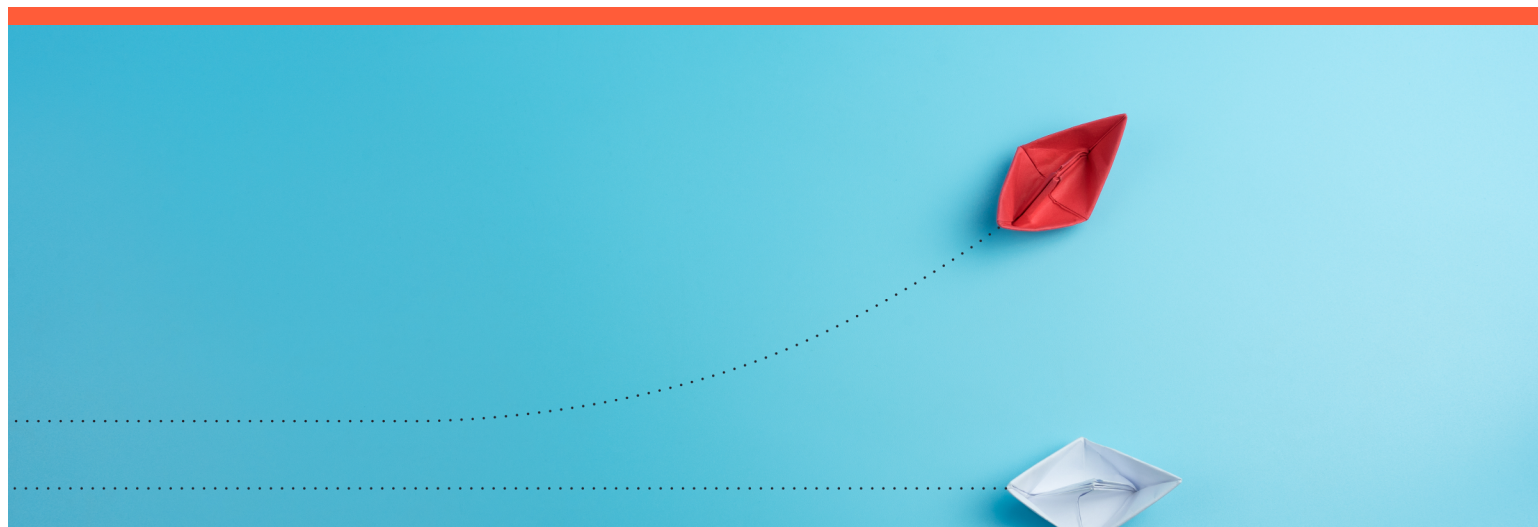
Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members at a set rate. Health care providers are not able to charge insureds more than the negotiated fee set by the insurance provider.

What is Out-of-Network?

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

What is an Explanation of Benefits (EOB)?

An EOB is a description your insurance carrier sends to you explaining the health care benefits that you received and the services for which your health care provider has requested payment.



DENTAL COVERAGE

The following chart summarizes the benefits for the dental plans offered to all eligible employees of Orange County Academy of Sciences and Art. As an eligible employee, you may choose to enroll in one of the following plans.

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

	Anthem DHMO Net 2000A	Anthem Gold DPPO 100/90/60	
		In-Network	Out-of-Network*
Benefit Description & Procedure Code			
Annual Deductible Individual/Family	None	\$50 / \$150 (Waived for Preventive Care)	\$50 / \$150 (Waived for Preventive Care)
Annual Maximum Benefit ** Per Member Enrolled	None	\$1,500	\$1,500
Preventive & Diagnostic Services			
Prophylaxis (Cleaning) D1110	No Charge	Plan 100%; You 0%	Plan 100%; You 0%
Bitewing X-rays D0272	No Charge	Plan 100%; You 0%	Plan 100%; You 0%
Basic Services			
Amalgam Restoration (Filling) One Surface D2140	No Charge	Plan 90%; You 10%	Plan 80%; You 20%
Endodontics Therapy (Root Canal) D3310	\$90 Copay	Plan 90%; You 10%	Plan 80%; You 20%
Major Services			
Porcelain Crown D2750	\$175 Copay***	Plan 60%; You 40%	Plan 50%; You 50%
Dentures D5110	\$175 Copay	Plan 60%; You 40%	Plan 50%; You 50%
Orthodontic Benefits			
Orthodontic Benefit (Adult/Child(ren))	Adult: \$1,895; Child: \$1,695	Plan 50%; You 50% (Child only)	Plan 50%; You 50% (Child only)
Lifetime Maximum Benefit	N/A	\$1,500 (Child only)	\$1,500 (Child only)

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

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

**Annual Maximum is based on the calendar year.

***Plus costs for noble or high noble metal, not to exceed \$125, and/or costs for porcelain, not to exceed \$100

PLEASE NOTE:

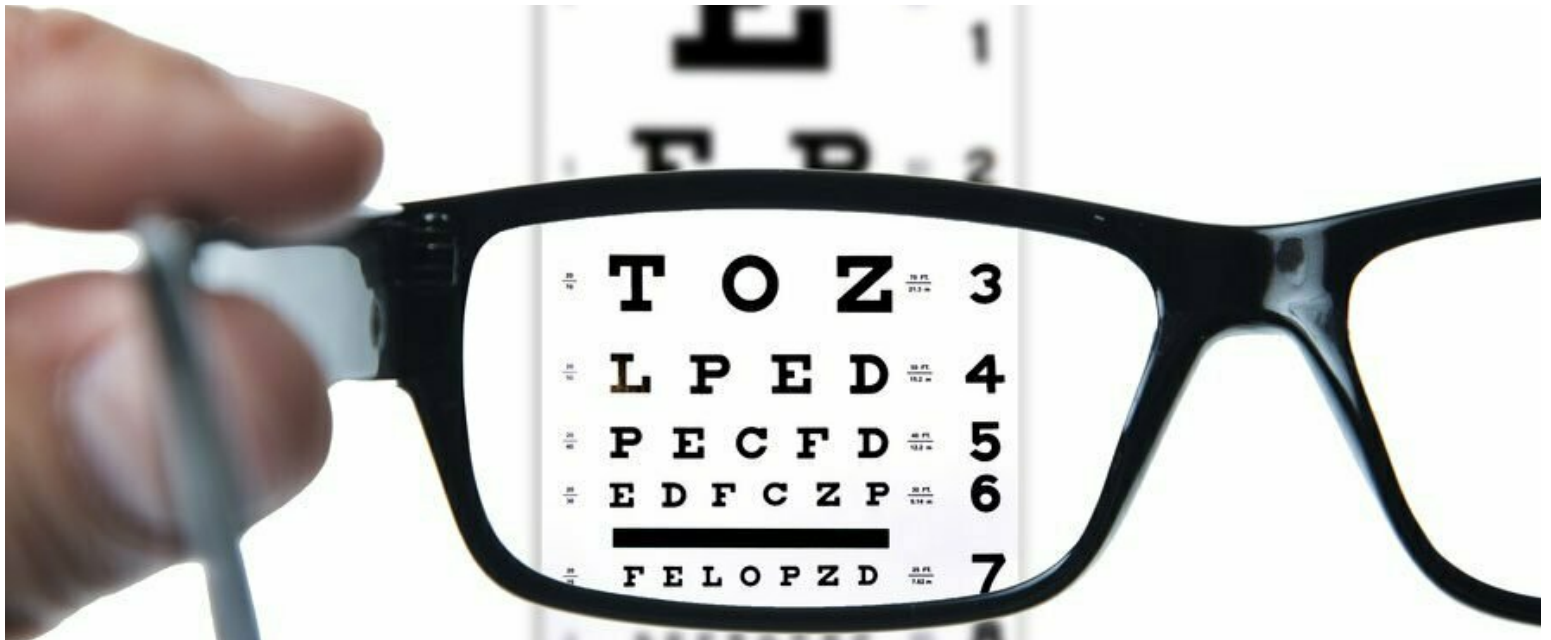
- If you elect Dental HMO (DHMO) coverage, you must select a contracted dentist from the DHMO Provider list. All care must be provided by the primary dentist.
- The Dental PPO (DPPO) plan provides you with the flexibility to receive services with a dental professional In-Network or Out-of-Network. As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

VISION COVERAGE

The following chart summarizes the benefits for the vision plan offered to all eligible employees of Orange County Academy of Sciences and Art.

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

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



LIFE & AD&D AND DISABILITY COVERAGE

Basic Life and AD&D Coverage

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

EMPLOYER PROVIDED LIFE INSURANCE	EMPLOYER PROVIDED ACCIDENTAL DEATH & DISMEMBERMENT
\$50,000	Same as basic life

This benefit will reduce to 65% at age 70; 50% at age 75.

Orange County Academy of Sciences and Art offers Short Term Disability (STD) through Colonial. These coverages provide financial assistance if you are unable to work for an extended period of time due to an illness or injury. Below are key highlights of the plan(s).

Voluntary Short-Term Disability

	STD Plan Highlights
Coverage Option	Up to 60% of monthly covered earnings
Elimination Period	7 Days
Maximum Benefit	\$7,500 Monthly
Maximum Benefit Duration	6 Months
Pre-existing Conditions	Does Not Apply

Supplemental Term Life and AD&D Coverage

As an employee of Orange County Academy of Sciences and Art, you have the option of purchasing additional life and AD&D coverage through Colonial Life. This voluntary policy enables you to purchase coverage for yourself and qualified dependents. When you enroll yourself and your dependents in this benefit, you pay the full cost through post-tax payroll deductions. Please note that elections made for Life coverage must match AD&D elections.

	Employee	Spouse/DP	Child(ren)
Coverage Option	Increments of \$1,000 up to \$300,000; But not to exceed 5 times salary	Increments of \$1,000 up to 100% of the employee amount	Birth to 6 months: \$1,000; 6 months and older: Increments of \$1,000 up to \$10,000
Guaranteed Issue Amount	\$100,000	\$30,000	All Amounts
Maximum Amount	\$300,000; But not to exceed 5 times salary	100% of the employee amount	\$10,000

This benefit will reduce to 65% at age 70; 50% at age 75.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSA)

Orange County Academy of Sciences and Art is pleased to offer employees a Flexible Spending Account (FSA) program. FSAs allow employees to set aside pre-tax dollars for qualified healthcare and/or dependent care expenses. The money that is deposited into your FSA comes directly from your gross pay, which reduces your taxable income. Enrollment in one or both of these accounts is optional. Benefit-eligible employees have the option to set aside funds into the following types of FSA:



General Purpose Healthcare FSA:

A Healthcare FSA allows you to use pre-tax dollars from your paycheck for eligible medical, dental and vision expenses incurred by you, your spouse and your tax dependents. In order for your expenses to qualify for reimbursement from your FSA they must be considered "qualified expenses" as deemed by the IRS. IRS publication 502 lists all qualified expenses including things such as; office visit copays, coinsurance payments, braces, eye exams, and much more. Please note cosmetic procedures are not considered FSA-qualified expenses. Paying for qualified medical expenses using this tax-free money can save you money! For the 2026 plan year, the maximum amount you can contribute into your healthcare FSA is \$3,400.

Dependent Care FSA:

Dependent care expenses that enable you (and your spouse, if applicable) to go to work and/or school full-time are eligible for reimbursement using tax-free money from your Dependent Care FSA (DCFSA). For expenses to qualify under this FSA, they must be related to the custodial care of your dependent(s) and must be incurred in order for you/your spouse to work. Schooling/tuition or the expenses for sending your child to an overnight camp are not reimbursable through the account. Additionally, payments made to one of your tax dependents, including your spouse or dependent child under the age of 19, are not reimbursable. For the 2026 plan year, the maximum amount you can contribute into your dependent care FSA is \$7,500 per household (or \$3,750 if married and filing separately).



Who qualifies as a dependent?

- Your federal tax dependent who is under the age of 13 (i.e. age 12 and under)
- Your federal tax dependent (including your spouse) who is physically or mentally incapable of caring for him/herself

Reimbursement from your DCFSA is easy! Download a reimbursement request form from www.goigoe.com and complete all sections. When complete, attach your back up documentation and send your request to IGOE. Once approved, reimbursement will be issued up to the available cash balance in your DFSA. Reimbursements are released on specific dates scheduled by your employer. Please review your Plan Highlights for more specific information on reimbursement release dates.

- The plan year runs from July 1, 2026 - June 30, 2027.
- The Healthcare FSA has a \$680 rollover feature.
- "Use it or Lose it" rule: remaining funds in the account are forfeited if claims are not submitted by the deadline.
- Enrollment does not continue automatically, you must re-enroll and elect contributions each year.
- You are responsible for keeping your receipts from eligible purchases made with your FSA funds. In the event you are asked to substantiate a charge, you must provide this information (usually within 30 days).



Have Questions?
Contact Participant Services
1-800-633-8818, option 1
flex@goigoe.com

Flexible Benefit Plan Highlights for Orange County Academy of Sciences and Arts

Plan Year: 7/1/2026 through 6/30/2027

Run Out Period: 9/30/2027 (Manual Claims can be submitted up through this date)

Existing Eligibility and Claim Submittal Deadlines:

Expense eligibility and claim submittal deadlines can vary by plan. We encourage you to visit our website, www.goigoe.com, to view expense eligibility. We also encourage you to set up an online account so that you can access a personalized timeline for expense eligibility and claim submittal.

Generally speaking, eligible expenses must be incurred during your active participation within the plan and/or within the Plan Year dates shown above (whichever period of time is shorter). If the plan you elect has the grace period feature, claims may be incurred through the Grace Period end date as shown in the Available Spending Accounts section (if applicable).

Claims for most plans must be submitted prior to the Run Out Period listed above. PLEASE NOTE: Claim and submittal timelines change if your participation ends within the plan year due to loss of employment or other eligibility changes. To keep track of your personal claim and submission timelines, please establish an account on Igoe Mobile (recommended) or on the Igoe Participant Portal.

Registration is a secure process, please see the "Get Started" section for registration information if you haven't established a personal account yet.

Available Spending Accounts

Medical Care Reimbursement Account

Reimburses certain out of pocket medical care expenses for you and your tax dependents

Grace Period End Date: 9/15/2027 (Claims can be incurred up through this date)

Term Submittal Deadline: 90 days following the date of termination

Maximum Election Allowed: \$3,400.00

Dependent Care Reimbursement Account

Reimburses certain day care related expenses

Grace Period End Date: 9/15/2027 (Claims can be incurred up through this date)

Term Submittal Deadline: September 30th following the close of the plan year

Maximum Election Allowed: \$7,500.00



Have Questions?
Contact Participant Services
1-800-633-8818, option 1
flex@goigoe.com

Getting Started

To get the most out of your plan/s, please register on Igoe Mobile from the primary account holders mobile device (recommended). Registration is a secure process that requires the use of a one-time password. If you are using the primary account holder's mobile device, this process is generally a lot easier. Once registered, your credentials will work on the Igoe Participant Portal as well.

For registration information and other user tips, please visit www.goigoe.com and scroll through the Resources section where you'll find useful tools, as well as our top user guides (like how to register, how to set up direct deposit, how to order dependent benefits cards, and more).



Employee Assistance Program Service Summary EAP with MyStrength



Available 24/7, 365 days a year
Everything you share is confidential.*

When you need help meeting life's challenges, the Anthem Employee Assistance Program (EAP) is here for you and your household members. Check out some of the services we offer — at no cost to you:



Counseling

- Up to 3 visits per issue
- Face-to-face counseling or online visits via LiveHealth Online
- Can call EAP or use the online Member Center to initiate services



Legal consultation

- 30-minute phone or in-person meeting
- Discounted fees to retain a lawyer
- Online resources, including free legal forms, seminars and a library of articles



Financial consultation

- Phone meeting with financial professionals
- Consultation available during regular business hours — no time limits or appointments needed
- Online resources, including articles, calculators and budgeting tools



ID recovery

- Identity theft risk level checked by specialists
- Help with reporting to consumer credit agencies
- Assistance filling out paperwork and negotiating with creditors



myStrength

- Online “health club for your mind”
- E-learning modules and mood trackers
- Library of videos, articles and inspirational quotes
- Supports development of personal action plans



Dependent care and daily living resources

- Information available on child care, adoption, summer camps, college placement, elder care and assisted living through the EAP website
- For help with everyday needs, like pet sitting, relocation resources and more



Other anthemEAP.com resources

- Well-being articles, podcasts and monthly webinars
- Self-assessment tools for depression, anxiety, relationships, alcohol use, eating habits and more



Crisis consultation

- Toll-free number for emergencies
- Round-the-clock help available
- Critical event support online to help with planning, coping and recovery resources when tragedy strikes

Need help? Give EAP a try today.

Call us at 800-999-7222, use our Sydney Health app, or go to anthemEAP.com and enter your company code: My EAP CA.

* In accordance with federal and state law, and professional ethical standards.
This document is for general informational purposes. Check with your employer for specific information about benefits, limitations and exclusions.

Language Access Services – (TTY/TDD: 711)

Spanish – Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.

Chinese – 您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。

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

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

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Get the emotional support you need – whenever you need it.

Text with a coach using the Ginger app

We're working with Ginger to help you cope with some of life's most common challenges – from stress and low mood to issues with work, relationships, and sleep.

Ginger's skilled emotional support coaches are accessible 24/7, so you can get the guidance you need when you need it most.

Kaiser Permanente members can use Ginger at no cost, no referral needed.^{1,2,3,4}



What can you do with Ginger?

- Text with your coach on the Ginger app now or schedule a time to connect later.
- Discuss goals, share challenges, and create an action plan with your coach.
- Get personalized, interactive skill-building tools from your coach and a library of more than 200 activities on the app.
- View recaps from each texting session and track your progress.
- Work with your coach to adjust your action plan if needed to better help you reach your goals.

1. The Ginger app and coaching services described above are not covered under your health plan benefits, are not a Medicare-covered benefit, and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may be discontinued at any time without notice. The app and coaching services are not available to any members under 18 years old. **2.** The app and coaching services are neither offered nor guaranteed under contract with the FEHB Program, but are made available to enrollees and family members, 18 and older, who become members of Kaiser Permanente. **3.** The app and coaching services are not available to Medi-Cal members. **4.** Kaiser Permanente members can text with a coach using the Ginger app for 90 days per year. After the 90 days, members can continue to access the other services available on the Ginger app for the remainder of the year at no cost.

Download Ginger now at kp.org/coachingapps/scal



Support for emotional wellness

Try our on-demand self-care apps today at no additional cost

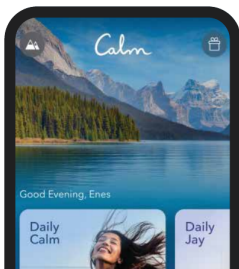
Get help with anxiety, stress, sleep, mood, and more. Anytime you need it.

Kaiser Permanente members can explore 3 evidence-based apps:^{1,2,3}



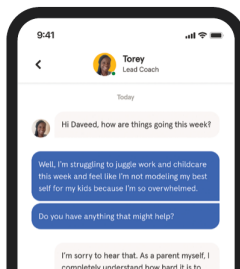
Calm is the number one app for meditation and sleep.⁴ You can choose from hundreds of programs and activities, including:

- Guided meditations
- Sleep Stories
- Mindful movement videos



Headspace Care (formerly called Ginger) offers 1-on-1 emotional support coaching and self-care activities to help with many common challenges.

- Coaches are available by text 24/7
- You can use Headspace Care's text-based coaching services at no cost, no referral needed^{5,6}



myStrength provides personalized programs designed to help you:

- Set mental health goals
- Learn coping skills
- Track your progress over time
- Make positive changes



Visit kp.org/selfcareapps to get started

1. The apps and services described above are not covered under your health plan benefits, are not a Medicare-covered benefit, and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. The apps and services may be discontinued at any time.

2. The apps and services are neither offered nor guaranteed under contract with the FEHB Program, but are made available to enrollees and family members who become members of Kaiser Permanente.

3. Calm and myStrength can be used by members 13 and over. The Headspace Care app and services are not available to any members under 18 years old.

4. Calm is the number one app for sleep, meditation, and relaxation. Learn more at calm.com/blog/about.

5. Some individuals who receive health care services from Kaiser Permanente through state Medicaid programs are not eligible for the Headspace Care app and services. The Headspace Care app and services are not available to anyone enrolled in a Fee-for-Service Medicaid program.

6. Eligible Kaiser Permanente members can text with a coach using the Headspace Care app for 90 days per year. After the 90 days, members can continue to access the other services available on the Ginger app for the remainder of the year at no cost.

Calm, Headspace Care, and myStrength are not available to Kaiser Permanente Dental-only members.

Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 1300 SW 27th St., Renton, WA 98057

Learn more at kp.org/selfcareapps





Voluntary benefits



Orange County Academy of
Science and Arts

To learn more, contact:

Jennifer Ramirez
Account Executive
619-993-6300

Jennifer.Ramirez@coloniallife-
sales.com

ColonialLife.com

NS-16028

Choices to protect what you've worked so hard to build

Each individual's lifestyle and needs are different from the next. Voluntary benefits from Colonial Life — on both an individual and group platform — offer a broad range of financial protection options for employees and their families.

Disability Insurance

- **Group Disability** – A short-term disability product that replaces a portion of income for on/off-job or off-job only disabilities. Optional features include psychiatric and psychological conditions benefits and waiver of elimination period for first day hospital confinement. Guaranteed-issue and simplified-issue options are available.

Accident Insurance

- **Group Accident** – A guaranteed-issue, composite-rated group accident product with multiple coverage levels to fit employer and employee needs. All plans are compliant with health savings accounts (HSA) and provide all employees the same benefits and rates. Spouse and eligible dependent children coverage is also available.

Special Risk Insurance

- **Group Critical Care** – A critical care product that provides a lump-sum benefit when a covered critical illness or cancer is diagnosed. The product may also provide monthly benefits for extended treatment of cancer. Features include subsequent diagnosis, HSA-compliant plans and portability.

Supplemental Health insurance

- **Group Medical BridgeSM** – A hospital confinement indemnity product that pays benefits to help cover out-of-pocket expenses associated with a covered hospital stay, outpatient surgeries, diagnostic procedures and health screenings. Choose from employer- and employee-paid plans. An HSA-compliant plan is available, as well as guaranteed-issue plans that ask no health questions.

3-17 | NS-16028



Important coverage features:

- With most products, coverage is available to spouses and eligible dependent children.
- Benefits are paid directly to the insured, unless specified otherwise.
- With most products, employees can continue coverage with no increase in premiums if they retire or change jobs.
- With most products, employees may receive benefits regardless of any other insurance.
- Premiums are payroll deducted for easy administration.

Learn more about
what we have to offer
at ColonialLife.com.

ColonialLife.com

NS-16028

ACCIDENT, CANCER, CRITICAL ILLNESS, AND HOSPITAL INDEMNITY PRODUCTS PROVIDE LIMITED BENEFITS.

The policies, their names or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. See the actual policy or your Colonial Life representative for specific provisions and details of availability. Insurance products are underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

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Choose the benefits that are right for you

Enroll May 22, 2026 – June 3, 2026

Orange County Academy is pleased to offer a variety of benefits during your upcoming enrollment. You will have the opportunity to speak with a benefits counselor during open enrollment to find out about all of your benefit options.

The following core benefits will be offered during enrollment:

- Medical insurance
- Vision insurance
- Dental insurance
- Flexible spending accounts

You also have the opportunity to apply for these Colonial Life voluntary benefits:

Group Accident Insurance can provide a benefit for a range of accidental injuries and treatments. You can use the money however you choose.

Group Disability Insurance helps replace a portion of your income to help make ends meet if you become disabled from a covered accident or sickness.

Group Critical Illness Insurance provides a benefit to help you manage the financial impacts of a critical illness.

Group Hospital Indemnity Insurance provides a benefit for hospital confinement or outpatient surgery to help with deductibles.

When it's time to enroll, you need to have the following items:

- Your employee identification number
- The name, SSN, date of birth and address of all dependents you wish to enroll
- Life insurance beneficiary information

How to Enroll:

Scheduler: Meet with a benefits counselor during open enrollment to ask questions and enroll.

Go to: <https://calendly.com/margo-ramirez/orange-co-academy-of-science-arts> or scan the QR code with your phone camera to schedule your benefits enrollment session.



If you have questions about your enrollment contact:

Margo Ramirez Benefits Counselor

760-917-8483

margo.ramirez@ColonialLifesales.com

EMPLOYEE CONTRIBUTIONS

Monthly Payroll Deductions				
	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical				
Anthem HMO	Rates are age-banded. Please check your IGNITE portal for more information.			
Kaiser HMO				
Anthem PPO				
	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Dental & Vision				
Anthem Dental DHMO	\$1.42	\$13.75	\$29.60	\$29.60
Anthem Dental DPPO	\$36.36	\$85.52	\$104.12	\$160.96
Anthem Vision	\$1.28	\$8.42	\$7.32	\$14.82

Enrollment Checklist

- ☐ Gather Social Security numbers and dates of birth for you and your qualified dependents whom you want to enroll. Choose the plans and coverage levels that best meet your needs. Take time to review the benefit outlines provided in this guide. This will help you understand the plans that are offered and how they may fit your lifestyle and budget.
- ☐ Make sure that your family doctor(s) and dentist(s) are covered by the plans you have chosen.
- ☐ Decide how much to contribute to your Flexible Spending Accounts (FSAs) to help save on taxes while paying for qualified healthcare and dependent care.

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

Carrier Contact Information

Administrator	Benefit	Phone	Website
Anthem Blue Cross	Medical HMO & PPO	(855) 383-7248	www.anthem.com/ca
Kaiser Permanente	Medical HMO	(800) 464-4000	www.kp.org
Anthem Blue Cross	Dental HMO	(800) 627-0004	www.anthem.com/ca
Anthem Blue Cross	Dental PPO	(877) 567-1804	www.anthem.com/ca
Anthem Blue Cross	Vision	(866) 723-0515	www.anthem.com/ca
Colonial Life	Basic Life & AD&D	(800) 325-4368	www.coloniallife.com
Colonial Life	Voluntary Supplemental Benefits	(800) 845-7330	www.coloniallife.com
Colonial Life	Voluntary/Worksite Benefits	(800) 325-4368	www.coloniallife.com
IGOE	FSA	(800) 633-8818	www.goigoe.com

ANNUAL HEALTH PLAN

IMPORTANT NOTICES

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

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

Below are highlights to note:

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

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

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

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

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

DATE: 07/01/2026
NAME: Dot Blanchi
POSITION: Director of Admissions and Operations
ADDRESS: 30011 Ivy Glenn Dr., Suite 125
Laguna Niguel, CA 92677
PHONE NUMBER: (949) 269-3293
OTHER CONTACT INFORMATION: dmblanchi@ocasa.org

Notice: Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, see the contact information at the end of these notices. A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

Notice: HIPAA Notice of Privacy Practice

Your Information. Your Rights. Our Responsibilities.

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

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

Your Rights	When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
Get a copy of health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. • We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share	- You can ask us not to use or share certain health information for treatment, payment or our operations. - We are not required to agree to your request, and we may say “no” if it would affect your care.
Get a list of those with whom we’ve shared information	- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with and why. - We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. - We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	- You can complain if you feel we have violated your rights by contacting us using the information on page 32. - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. - We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what to share.

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

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

Our Uses and Disclosures

How do we typically use or share your health information.

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

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

Uses and disclosures of certain substance use disorder treatment records

If we receive or maintain any information about you from a substance use disorder treatment program that is covered by Section 543 of the PHSA (42 USC 290dd-2) and 42 CFR Part 2 (a “Part 2 Program”) through a general consent you provide to the Part 2 Program to use and disclose those records for purposes of treatment, payment, or health care operations, we may use and disclose those records for treatment, payment, and health care operations purposes as described in this notice. However, we will not use or disclose a Part 2 Program record about you, or testimony that describes the information contained in a Part 2 Program record about you, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority against you, unless authorized by your consent or the order of a court after it provides you notice of the court order. Although we do not anticipate using any Part 2 Program records for fundraising purposes, you will be provided with a clear and conspicuous opportunity to elect not to receive any fundraising communications from us before we will use any Part 2 Program records for fundraising purposes.

How else can we use or share your health information?

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

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

Our Responsibilities

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

Notice: Consolidated Omnibus Budget Reconciliation Act (COBRA)

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Continuation Coverage Available?

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

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

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

How is COBRA Continuation Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

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

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

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

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

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

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

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

For more information visit <https://www.medicare.gov/medicare-and-you>. 26

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

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

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

NOTICE: NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following 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).

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

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

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

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

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2026. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ARKANSAS – Medicaid
WEBSITE: http://www.myalhipp.com PHONE: (855) 692-5447	WEBSITE: http://myarhipp.com/ PHONE: (855) MyARHIPP (855-692-7447)
ALASKA – Medicaid	CALIFORNIA – MEDICAID
THE AK HEALTH INSURANCE PREMIUM PAYMENT PROGRAM WEBSITE: http://myakhipp.com/ PHONE: (866) 251-4861 EMAIL: CustomerService@MyAKHIPP.com MEDICAID ELIGIBILITY: WEBSITE: https://health.alaska.gov/dpa/Pages/default.aspx	HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM WEBSITE: http://dhcs.ca.gov/hipp PHONE: (916) 445-8322 Fax: (916) 440-5676 EMAIL: hipp@dhcs.ca.gov
COLORADO – HEALTH FIRST COLORADO (COLORADO’S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)	FLORIDA – MEDICAID
HEALTH FIRST COLORADO WEBSITE: HTTPS://HEALTHFIRSTCOLORADO.COM/ HEALTH FIRST COLORADO MEMBER CONTACT CENTER: (800) 221-3943 / STATE RELAY 711 CHP+: HTTPS://HCPF.COLORADO.GOV/CHILD-HEALTH-PLAN-PLUS CHP+ CUSTOMER SERVICE: (800) 359-1991 / STATE RELAY 711 HEALTH INSURANCE BUY-IN PROGRAM (HIBI): HTTPS://WWW.MYCOHIBI.COM/ HIBI CUSTOMER SERVICE: (855) 692-6442	WEBSITE: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html PHONE: (877) 357-3268
GEORGIA – MEDICAID	INDIANA – MEDICAID
GA HIPP WEBSITE: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp PHONE: (678) 564-1162, PRESS 1 GA CHIPRA WEBSITE: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra PHONE: (678) 564-1162, Press 2	HEALTHY INSURANCE PREMIUM PAYMENT PROGRAM ALL OTHER MEDICAID WEBSITE: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ FAMILY AND SOCIAL SERVICES ADMINISTRATION PHONE: (800) 403-0864 MEMBER SERVICES PHONE: (800) 457-4584
IOWA – MEDICAID AND CHIP (HAWKI)	KANSAS – MEDICAID
MEDICAID WEBSITE: Iowa Medicaid Health & Human Services PHONE: (800) 338-8366 HAWKI WEBSITE: Hawki - Healthy and Well Kids in Iowa Health & Human Services PHONE: (800) 257-8563 HIPP WEBSITE: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) PHONE: (888) 346-9562	WEBSITE: https://www.kancare.ks.gov/ PHONE: (800) 792-4884 HIPP PHONE: (800) 967-4660
KENTUCKY – MEDICAID	LOUISIANA – MEDICAID
KENTUCKY INTEGRATED HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (KI-HIPP) WEBSITE: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx PHONE: (855) 459-6328 EMAIL: KIHIPPPROGRAM@ky.gov KCHIP WEBSITE: https://kynect.ky.gov PHONE: (877) 524-4718 KENTUCKY MEDICAID WEBSITE: https://chfs.ky.gov/agencies/dms	LOUISIANA MEDICAID WEBSITE: https://www.ldh.la.gov/healthy-louisiana MEDICAID CUSTOMER SERVICE LINE: (888) 342-6207 LOUISIANA MEDICAID EMAIL: healthy@la.gov LOUISIANA HEALTH INSURANCE PREMIUM PROGRAM (LAHIPP) WEBSITE: www.ldh.la.gov/lahipp LAHIPP PHONE: (877) 697-6703 LAHIPP FAX: (888) 716-9787 LAHIPP EMAIL: La.HIPP@la.gov LAHIPP MAILING ADDRESS: 100 CRESCENT CENTRE PARKWAY, SUITE 1000, TUCKER, GA 30084

MAINE – MEDICAID	MASSACHUSETTS – MEDICAID AND CHIP
ENROLLMENT WEBSITE: https://www.mymaineconnection.gov/benefits/s/?language=en_US PHONE: (800) 442-6003 TTY: Maine Relay 711 PRIVATE HEALTH INSURANCE PREMIUM WEBPAGE: https://www.maine.gov/dhhs/ofi/applications-forms PHONE: (800) 977-6740 TTY: Maine Relay 711	WEBSITE: https://www.mass.gov/masshealth/pa PHONE: (800) 862-4840 TTY: 711 EMAIL: masspremassistance@accenture.com
MINNESOTA – MEDICAID	MISSOURI – MEDICAID
WEBSITE: https://mn.gov/dhs/health-care-coverage/ PHONE: (800) 657-3739	WEBSITE: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm PHONE: (573) 751-2005
MONTANA – MEDICAID	NEBRASKA – MEDICAID
WEBSITE: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP PHONE: (800) 694-3084 EMAIL: HSHIPPPProgram@mt.gov	WEBSITE: http://www.ACCESSNebraska.ne.gov PHONE: (855) 632-7633 LINCOLN: (402) 473-7000 OMAHA: (402) 595-1178
NEVADA – MEDICAID	NEW HAMPSHIRE – MEDICAID
WEBSITE: https://dhcfp.nv.gov/ PHONE: (800) 992-0900	WEBSITE: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program PHONE: (603) 271-5218 TOLL FREE NUMBER FOR THE HIPP PROGRAM: (800) 852-3345 Ext. 15218 EMAIL: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – MEDICAID AND CHIP	NEW YORK – MEDICAID
MEDICAID WEBSITE: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ MEDICAID PHONE: (800) 356-1561 CHIP PREMIUM ASSISTANCE PHONE: (609) 631-2392 CHIP WEBSITE: http://www.njfamilycare.org/index.html CHIP PHONE: (800) 701-0710 TTY: 711	WEBSITE: https://www.health.ny.gov/health_care/medicaid/ PHONE: (800) 541-2831
NORTH CAROLINA – MEDICAID	NORTH DAKOTA – MEDICAID
WEBSITE: https://medicaid.ncdhhs.gov/ PHONE: (919) 855-4100	WEBSITE: https://www.hhs.nd.gov/healthcare PHONE: (844) 854-4825
OKLAHOMA – MEDICAID AND CHIP	OREGON – MEDICAID
WEBSITE: http://www.insureoklahoma.org PHONE: (888) 365-3742	WEBSITE: http://healthcare.oregon.gov/Pages/index.aspx PHONE: (800) 699-9075
PENNSYLVANIA – MEDICAID AND CHIP	RHODE ISLAND – MEDICAID AND CHIP
WEBSITE: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html PHONE: (800) 692-7462 CHIP WEBSITE: Children's Health Insurance Program (CHIP) (pa.gov) PHONE: (800) 986-KIDS (5437)	WEBSITE: http://www.eohhs.ri.gov/ PHONE: (855) 697-4347 or (401) 462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA – MEDICAID	SOUTH DAKOTA - MEDICAID
WEBSITE: https://www.scdhhs.gov PHONE: (888) 549-0820	WEBSITE: http://dss.sd.gov PHONE: (888) 828-0059

TEXAS – MEDICAID	UTAH – MEDICAID AND CHIP
WEBSITE: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services PHONE: (800) 440-0493	UTAH'S PREMIUM PARTNERSHIP FOR HEALTH INSURANCE (UPP) MEDICAID WEBSITE: https://medicaid.utah.gov/upp/ EMAIL: upp@utah.gov PHONE: (888) 222-2542 ADULT EXPANSION WEBSITE: https://medicaid.utah.gov/expansion/ UTAH MEDICAID BUYOUT PROGRAM WEBSITE: https://medicaid.utah.gov/buyout-program/ CHIP WEBSITE: http://chip.utah.gov/
VERMONT– MEDICAID	VIRGINIA – MEDICAID AND CHIP
WEBSITE: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access PHONE: (800) 250-8427	WEBSITE: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs MEDICAID & CHIP PHONE: (800) 432-5924
WASHINGTON – MEDICAID	WEST VIRGINIA – MEDICAID AND CHIP
WEBSITE: https://www.hca.wa.gov/ PHONE: (800) 562-3022	WEBSITE: https://dhhr.wv.gov/bms/http://mywvhpp.com/ MEDICAID PHONE: (304) 558-1700 CHIP TOLL-FREE PHONE: (855) MyWVHIPP (699-8447)
WISCONSIN – MEDICAID AND CHIP	WYOMING – MEDICAID
WEBSITE: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm PHONE: (800) 362-3002	WEBSITE: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ PHONE: (800) 251-1269

To see if any other States have added a premium assistance program since January 31, 2026, or for more information on *Special Enrollment Rights*, contact either:

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

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

OMB Control Number 1210-0137 (Expires: 2/28/2026)

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and posted electronically.

For more information, contact:

Name: Dot Blanchi
Title: Director of Admissions and Operations
Address: 30011 Ivy Glenn Dr., Suite 125 Laguna Niguel, CA 92677
Telephone Number: (949) 269-3293
Other contact information: dmbianchi@ocasa.org

Effective date of this Notice

January 1, 2026

Notes

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Notes

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