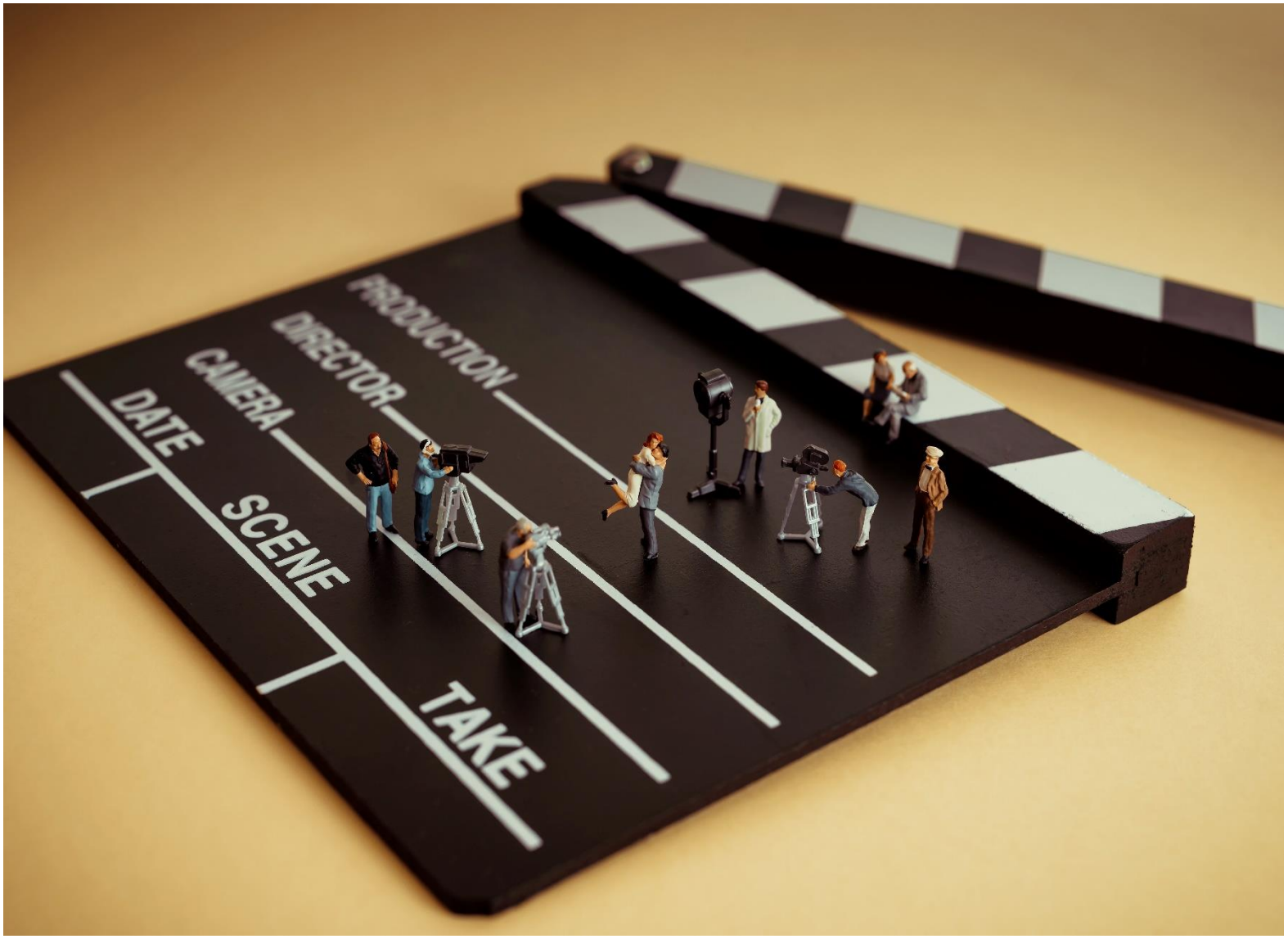
PHBP

Producers' Health Benefits Plan

California Freelance Benefit Enrollment Guide

2024 New and Renewing Enrollees



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A Message from Producers' Health Benefits Plan

To all Freelance Employees covered by PHBP:

Congratulations, you are receiving this Benefit Enrollment Guide because you are eligible to enroll in or renew benefits provided by the PHBP. Your free, employer paid benefits include 12 months of medical, pharmacy, vision, dental, basic life & accidental death and dismemberment and both short and long term disability coverage. Additional Voluntary Benefits are also available for purchase. At the Producers' Health Benefits Plan our goal is to provide a comprehensive benefits package that is easy to understand, easy to access and affordable for all. This enrollment guide provides the details that will help you assess the value of these options for you and your family. Please also visit PHBP.org to see the new Wellness and Perks section with Employee self-care programs offered by Anthem, perks for members and discounts for programs and products that promote employee wellness and wellbeing.

Synergy Enrollment will continue to manage the online enrollment process that includes scheduled, one-on-one telephone appointments with qualified Benefits Counselors to help you understand the details of each plan and the value they may offer. At the online portal you'll find a contribution calculator to help you figure out the costs of coverage for any of the voluntary benefits you may wish to purchase. Instructions on how to enroll are found in this guide.

The Plan also offers online payment options, allowing you to set up recurring payments and use a credit or debit card to pay bills online, including the mandatory $300 annual administrative fee. Be sure to make your payment prior to your effective date of coverage to prevent termination of benefits. Please see the invoice that accompanied your eligibility notice for more details.

Thank you for choosing PHBP. We've got you covered.

Sincerely,

The Producers' Health Benefits Plan

Open Enrollment

Open Enrollment is the 30 days prior to the effective date of your Coverage Period and takes place once a year and provides you with the opportunity to make changes to your benefit selections if you are continuing coverage or make your initial benefit selections if you are enrolling for the first time or had a break in coverage. This is also when you may add/remove dependents. Once you enroll, you may not change or cancel your coverage until the next Open Enrollment period unless you have a qualified family status change. **All coverage changes made during open enrollment will be effective the first of the month in which your 2024 coverage period begins. See below for important information about enrolling eligible dependents.**

Insurance Benefits: **All** Benefits will be provided by Anthem.

The PHBP will continue to offer the following Insurance Benefits;

- **Medical and Prescription Drug**:
  - HMO (California only)
  - Classic Plus PPO
  - Classic Premier PPO
  - High Deductible Health Plan with a Health Savings Account (HDHP w/ HSA)
  - Includes access to 24/7 online virtual doctor visits.

- **Vision and Dental**
- **Basic Life Insurance, Accidental Death & Dismemberment, Short & Long Term Disability**
  - Includes access to a 24/7 Employee Assistance Program.
- **Supplemental Life Insurance**
  - Not included with Enrollment - Available for purchase

Anthem offers the following Voluntary Benefits for purchase:

- Accident
- Critical Illness
- Hospital Indemnity

2024 Changes

- High Deductible Health Plan with Health Savings Account (HSA): The individual with the family deductible will increase to $3,200, meaning no one family member can contribute more than $3,200 towards the family deductible.

- Heath Savings Account annual contribution limits have increased from $3,850 to $4,150 for an individual and from $7,750 to $8,300 for a family.

Income Tiers, Coverage Choices, and Dependent Costs:

The medical plan available to you will be based on your Income Tier. Your Income Tier will be determined by your reported earnings in the *qualifying* period in which you earned eligibility for your next *coverage* period. "Reported Earnings" mean the gross income paid on covered jobs, in covered job categories, for work performed for Participating Employers, for which contributions were received by the Plan. All of the below costs, if any are monthly.

<table>
<tr><th>Tier Level</th><th>Annual Reported Income</th><th>Available Medical Coverage</th></tr>
<tr><td>Tier 1</td><td>Up to $49,999</td><td><u>California Classic HMO</u>
• Cost to Freelance Participant: No Charge
• Cost for Dependents: $250 for first dependent, $100 for each thereafter

-OR-

<u>High Deductible Health Plan with Health Savings Account ("HSA")</u>
• Cost to Freelance Participant: No Charge
• Cost for Dependents: $250 for first dependent, $100 for each thereafter
• Incentive for enrolling in the HSA: $125 monthly credit against any dependent fees. Waived $300 annual Administrative fee

If no choice is made within 30 days of the start of coverage, the HMO is the default Medical Plan.</td></tr>
<tr><td>Tier 2</td><td>$50,000 - $109,999</td><td><u>California Classic HMO</u>
• Cost to Freelance Participant: No Charge
• Cost for Dependents: $250 for first dependent, $100 for each thereafter

-OR-

<u>High Deductible Health Plan with Health Savings Account ("HSA")</u>
• Cost to Freelance Participant: No Charge
• Cost for Dependents: $250 for first dependent, $100 for each thereafter
• Incentive for enrolling in the HSA: $125 monthly credit against any dependent fees. Waived $300 annual Administrative fee

-OR-

<u>Classic PLUS PPO</u>
• Buy-up Cost to Freelance Participant:
<table><tr><td>○ Employee Only: $185</td><td>○ Employee + Spouse: $400</td></tr><tr><td>○ Employee + Child(ren): $325</td><td>○ Employee + Family: $550</td></tr></table>
-OR-

<u>Classic PREMIER PPO</u>
• Buy-up Cost to Freelance Participant:
<table><tr><td>○ Employee Only: $345</td><td>○ Employee + Spouse: $755</td></tr><tr><td>○ Employee + Child(ren): $620</td><td>○ Employee + Family: $1,065</td></tr></table>
If no choice is made within 30 days of the start of coverage, the HMO is the default Medical Plan.</td></tr>
<tr><td>Tier 3</td><td>$110,000 and above</td><td><u>California Classic HMO</u>
• Cost to Freelance Participant: No Charge
• Cost for Dependents: $250 for first dependent, $100 for each thereafter

-OR-

<u>High Deductible Health Plan with Health Savings Account ("HSA")</u>
• Cost to Freelance Participant: No Charge
• Cost for Dependents: $250 for first dependent, $100 for each thereafter
• Incentive for enrolling in the HSA: $125 monthly credit against any dependent fees. Waived $300 annual Administrative fee

-OR-

<u>Classic Premier PPO</u>
• Cost to Freelance Participant: No Charge
• Cost for Dependents: $250 for first dependent, $100 for each thereafter

If no choice is made within 30 days of the start of coverage, the HMO is the default Medical Plan.</td></tr>
</table>

You can find your reported earnings on the eligibility notice you received from the plan.

All California Freelance Medical Plans – An Overview

Classic Plus PPO and Classic Premier PPO

The Anthem PPO plans allow for more flexibility, but more responsibility on your part. You are not required to select a primary care physician. You may access specialist care directly – no referrals are required. A low $25 to $30 co-pay applies for regular office visits with in-network providers and a $500 deductible must be reached before your 20% co-insurance is due for care not covered by a co-pay and provided by an in-network provider. When you utilize doctors that are in the Anthem PPO network, you receive the advantage of a higher benefit level. Receiving care from out of network doctors will result in higher out of pocket costs.

The Plus and Premier PPO plans are similar but different, mostly distinguished by a slight difference in co-pay amounts, prescription drug benefits and both in-network and out-of-network out of pocket maximums. See the following comparative chart for more details. Instructions on how to find in-network doctors and details on 24/7 virtual doctor visits with Live Health Online can be found in the "Additional Resources" section at the end of this Guide.

California Classic HMO (Available in California only)

With an HMO, you and each of your covered family members select a primary care physician who will coordinate your entire healthcare program. You will work closely with this doctor to determine the care needed. To see a specialist, have laboratory or other diagnostic tests, or to be admitted to the hospital on a non-emergency basis, your primary care physician will have to pre-authorize these services and all referrals will be made to in-network providers. The HMO plan generally offers a high coverage level for most services, with minimal out-of-pocket expenses with a $0 deductible and low prescription drug costs. Instructions on how to find in-network doctors and details on 24/7 virtual doctor visits with Live Health Online can be found in the "Additional Resources" section at the end of this Guide.

High Deductible Health Plan with Health Savings Account (HSA)

The High Deductible Health Plan ("HDHP") is an IRS qualified PPO. If you select this plan, you have the option of enrolling in a triple tax advantaged Health Savings Account (HSA).

Insurance Terminology Glossary

	**Deductible:** The amount you must pay before the plan begins sharing in the costs. You pay this full amount out-of-pocket. Once your deductible is met, it is met for the remainder of the year and resets every January 1st.
	**Out-of-Pocket Maximum:** Protects you from big medical bills. This is the most you would pay for eligible expenses during a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. Some charges do not count toward the out-of-pocket max, such as unapproved charges, out of network "balance billing."
	**Co-pays:** A fixed amount you pay for a service (for example, $25 you pay for each regular doctor visit in the Premier PPO plan). Copayments are paid up front at the time of service. There may be different copay amounts for different services. Does NOT count towards your deductible.
	**Co-insurance:** When you pay a percentage of the cost and your insurance pays the rest, your share is called your "co-insurance" amount.
	**In Network:** Discounted rates for health care services provided by doctors, hospitals, and other providers that contract with the insurance company.
	**Out of Network:** Out of network providers are doctors, hospitals and other providers that do not offer their health services at a discounted rate because they are not contracted with the insurance company.
	**Pre-Tax: Deducted from payroll prior to taxes taken, lowering taxable income. Post-Tax**: Deducted or Contributed after taxes have been taken out. If the contribution made is tax deductible, the tax refund is claimed when you file your taxes.

High Deductible Health Plan with Health Savings Account (HSA)

HSA enrollment is the biggest trend in employee benefits. While the details may not be familiar to everyone, you may find the cost savings (for those in Tier Two who are contemplating 'buying-up') and tax benefits to be advantageous. In its simplest terms, a Health Savings Account ("HSA") is a personal savings account for healthcare spending, saving and investing. An HSA is an IRS qualified Health Savings Account and must accompany enrollment in a High Deductible Health Plan ("HDHP"). The Savings Account and High Deductible Health Plan are collectively referred to as "The HSA" in this guide. The HSA is a PPO and utilizes the same large network of providers as our other PPO plans. While the deductible is higher, the cost of coverage is lower than any other medical plan offered. The cost savings and tax benefits may be advantageous with significant retirement benefits as well.

The idea behind the HSA is that you make contributions into the Health Savings Account, and those funds are used to pay medical expenses. Your contributions are made post tax and deducted from income when you file your tax return. Funds may be invested and gains are tax free as well. All money coming out of the account remains tax free as long as the money is spent on approved medical expenses. Funds may be spent as needed on current medical expenses, saved for future medical expenses, or used at any time to reimburse yourself for medical expenses paid out of pocket while enrolled in the HSA.

Important Things To Know About The High Deductible Health Plan (HDHP) And Health Savings Account (HSA):

- You can use the funds for deductibles, co-pays, out of network doctor bills, prescriptions, acupuncture, birth control, contact lenses and cleaning solution… the IRS provides a complete list of approved medical expenses.
- You may also pay for your approved medical expenses out of pocket, save your receipts, let the account grow, and reimburse yourself at a later date tax free. Your tax free reimbursement can then be spent on anything.
- You can make regular post-tax direct deposits.
- HSA funds belong to you and unspent funds roll over year over year. It is not a 'use it or lose it" account.
- After age 65, your HSA funds may be used to pay Medicare premiums, long term care insurance and other elder care needs.
- Rules do apply. If funds from your HSA are used on unapproved expenses, the withdrawn amount becomes taxable income. If before age 65, there is an additional 20% penalty.
- See the HDHP with HSA Benefit Summary for complete details.
- Consult a tax professional to confirm your tax implications.
- Carefully consider your anticipated health care needs and premium contributions to establish which plan may be more beneficial to you and discuss your options with a Benefits Counselor as part of your enrollment process.

The HSA - continued

Coverage	2024 HSA Deductibles	2024 Calendar Year Contribution Limits*
Employee Only	$2,700	$4,150
Employee + Dependent(s)	$5,400	$8,300

- If you are 55 or older, you may make an additional "catch-up" contribution of up to $1,000 per calendar year.
- Employee contributions to their HSA are exempt from all federal taxes. State income taxes apply in California and New Jersey.
- Contribution limits are the aggregate of all sources of contributions.
- The individual within a family plan deductible is $3,200, meaning one member of the family must reach $3,200 before they max out and the rest of the family's combined deductible is $2,200 for a total family deductible of $5,400.

Once enrolled in the High Deductible PPO Health Plan, Anthem will open a Health Savings Account in your name and send you your account information so you may begin contributing. You will also receive a Debit Card linked to your account for the payment of approved medical expenses. From the Anthem website you can pay medical bills from your account, reimburse yourself for out of pocket expenses not paid with the provided debit card, submit claims, and manage your invested funds. You can choose to use the Anthem bank as custodian of your HSA account or use any banking institution of your choice that offers HSA accounts. See the "Additional Resources" section in the back of this Guide for instructions on how to deposit funds into your health savings account.

If you are enrolling in the HSA after the calendar year has started, your maximum account contribution for the year will be prorated based on the number of months left in the year. For example, if you open your HSA as of September 1, you may not contribute more than 4/12 of the maximums shown above.)

HSA Rules
You can contribute money to a Health Savings Account if: ▪ You are enrolled in a qualified high-deductible health plan. The PHBP High Deductible PPO is a qualified plan. ▪ You are not covered by any other medical plan, unless it is also a qualified high-deductible health plan. ▪ You are not enrolled in Medicare. ▪ You do not receive benefits under TRICARE. ▪ You cannot be claimed as a dependent on another person's tax return. ▪ You and your covered dependents do not participate in a health care flexible spending account, unless it is a "limited use FSA" that restricts reimbursement to certain benefits (such as dental and vision services). These are just the general guidelines. Please consult a tax professional and IRS Publication 969 for more information.

Watch the HSA overview video here for more information.

Please call the PHBP at 323-647-7427 or email the PHBP at SeanC@PHBP.org if you'd like to schedule a call to discuss the HSA in greater detail.

Comparison – the HSA vs the HMO

Below is a brief comparison between the High Deductible PPO and the HMO. Detailed benefit comparisons can be found on page 11.

	High Deductible PPO with HSA	HMO
What is it?	Large network PPO which allows you to see any doctor you want with costs covered based on carrier's "in network" and "out of network" cost structure. Patients pay all expenses until deductible is met, then share the costs of coverage with coinsurance.	Managed health plan where all provided services are performed "in network" with no deductible to be met. Patient pays small copay for services.
Primary Care Physician Required?*	No	Yes
Out of Network Coverage?	Yes	No
Referral needed to see a Specialist?	Generally No	Yes
In-Network Plan Design		
Coinsurance*	20%	None
Deductible - Individual	$2,700	None
Out-of-Pocket Maximum	$5,000	$2,000
Preventive Care	100% covered	100% covered
Hospital Services	20% coinsurance after deductible	$250 copay
Outpatient Surgery	20% coinsurance after deductible	$125 copay
Office Visit	20% coinsurance after deductible	$10 copay
Health Saving Account (HSA) Compatible?	Yes	No
HSA Tax Advantage	Money put in the HSA account is exempt from Federal and State Income Taxes (except CA and NJ)	None

* "Primary Care Physician" is the HMO 'gate keeper' doctor who manages all of your health care. All regular doctor visits must be with the Primary Care Physician, and all specialists must be approved by and referred by the Primary Care Physician to be covered.

Medical Plan Options

Medical Plan Options	PHBP Premier PPO		PHBP Classic Plus PPO		PHBP CA Classic HMO (CA Only)		PHBP Health Savings Account (HSA)	
DEDUCTIBLE	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Individual	$500	$1,500	$500	$1,500	$0	Not Applicable	$2,700	$8,100
Family	$1,000	$3,000	$1,000	$3,000	$0	Not Applicable	$5,400	$16,200
OUT-OF-POCKET MAX								
Individual OOP	$3,000	$6,000	$5,000	$14,000	$2,000	Not Applicable	$5,000	$15,000
Family OOP	$6,000	$12,000	$10,000	$28,000	$4,000	Not Applicable	$10,000	$30,000
PHYSICIAN SERVICES								
Office Visit Copays	$25 copay per visit	50% coinsurance	$30 copay per visit	50% coinsurance	$10 PCP / $30 SPC copay	Not Covered	20% coinsurance	50% coinsurance
Preventive Care	$0	50% coinsurance	$0	50% coinsurance	$0	Not Covered	$0	50% coinsurance
Diagnostic Lab/X-Ray	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	$0	Not Covered	20% coinsurance	50% coinsurance
Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	$100 copay per test	Not Covered	20% coinsurance	50% coinsurance
Rehabilitation/Habilitation (PT/OT/ST)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	$10 copay per visit	Not Covered	20% coinsurance	50% coinsurance
Chiropractic Care	$25 copay per visit	50% coinsurance	$30 copay per visit	50% coinsurance	$10 copay per visit	Not Covered	20% coinsurance	50% coinsurance
Acupuncture	$25 copay per visit	50% coinsurance	$30 copay per visit	50% coinsurance	$10 copay per visit	Not Covered	20% coinsurance	50% coinsurance
PRESCRIPTION DRUGS								
Tier 1a/ 1b (Generic Formulary)	$20	50% allowed amount to $250	$10/$30	50% allowed amount to $250	$5/$20	50% allowed amount to $250	$5/$15	50% allowed amount to $250
Tier 2 (Preferred Brand Formulary)	$40	50% allowed amount to $250	$50	50% allowed amount to $250	$40	50% allowed amount to $250	$40	50% allowed amount to $250
Tier 3 (Non-Preferred Brand Formulary)	$60	50% allowed amount to $250	$75	50% allowed amount to $250	$65	50% allowed amount to $250	$60	50% allowed amount to $250
Tier 4 (Specialty Drugs)	$500 Deductible 30% up to $150	50% allowed amount to $250	30% up to $250	50% allowed amount to $250	30% up to $250	50% allowed amount to $250	30% up to $250	50% allowed amount to $250
Mail Order (90 Day Supply)	T1: $20 T2: $80 T3: $100 T4: 30% up to $300	Not covered	T1:$20/$50 T2:$120 T3:$225 T4:30% up to $250	Not covered	T1:$12.50/$50 T2:$120 T3:$195 T4:30% up to $250	Not covered	T1:$12.50/$37.50 T2:$120 T3:$180 T4:30% up to $250	Not covered
HOSPITAL FACILITY SERVICES								
Inpatient Hospital Services	20% coinsurance plus $500	50% coinsurance	20% coinsurance plus $500	50% coinsurance	$250 copay per admit	Not Covered	20% coinsurance	50% coinsurance
Outpatient Surgery in Hospital	20% coinsurance plus $125	50% coinsurance	20% coinsurance plus $125	50% coinsurance	$125 copay per admit	Not Covered	20% coinsurance	50% coinsurance
Ambulatory Surgical Center	20% coinsurance plus $125	50% coinsurance	20% coinsurance plus $125	50% coinsurance	$125 copay per admit	Not Covered	20% coinsurance	50% coinsurance
EMERGENCY SERVICES								
Emergency Room	$150 copay per admit then 20% coinsurance	$150 copay per admit then 20% coinsurance	$150 copay per admit then 20% coinsurance	$150 copay per admit then 20% coinsurance	$100 copay per visit	Covered as In Network	20% coinsurance	20% coinsurance
Emergency Transport/Ambulance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	$100 copay per trip	Covered as In Network	20% coinsurance	20% coinsurance
Urgent Care	$25 copay per visit	50% coinsurance	$30 copay per visit	50% coinsurance	$10 copay per visit	Covered as In Network	20% coinsurance	50% coinsurance
MENTAL HEALTH/SUBSTANCE USE DISORDER								
Outpatient Services	$25 copay per visit	50% coinsurance	$30 copay per visit	50% coinsurance	$10 copay per visit	Not Covered	20% coinsurance	50% coinsurance
Inpatient Services	20% coinsurance plus $500	50% coinsurance	20% coinsurance plus $500	50% coinsurance	$250 copay per admit	Not Covered	20% coinsurance	50% coinsurance
MATERNITY								
Prenatal and Postnatal Care	$25 copay per visit	50% coinsurance	$30 copay per visit	50% coinsurance	$10 copay per visit	Not Covered	20% coinsurance	50% coinsurance
Delivery & All Inpatient Services	20% coinsurance plus $500	50% coinsurance	20% coinsurance plus $500	50% coinsurance	$250 copay	Not Covered	20% coinsurance	50% coinsurance

For more detailed descriptions of all lines of coverage, see the Summaries of Benefits in the "Insurance Provider Documents" section found here at the PHBP website.

Dental and Vision – Included with your Coverage

Dental Insurance

The Anthem PPO dental plan allows you to elect any dental provider, but you receive the highest level of coverage when you choose a network dentist.

PLAN BENEFITS	Anthem Dental PPO
	In-Network
Calendar Year Deductible Waived for Preventive Care	Individual: $50 Family: $150 Yes
Calendar Year Maximum	$1,500 per insured member
Preventive Services (Cleanings, exams, sealants, x-rays)	No Charge
Basic Services (Fillings, Periodontics, root canals, scaling, simple extractions)	20% after deductible
Major Services (Bridges & dentures, inlays, onlays, single crowns)	50% after deductible
Orthodontia Children Only	50% to $1,500 after deductible

+

* If using an out-of-network provider you will be responsible for amount over what is usual and customary. Out-of-Network Reimbursement is based on the 90th percentile.

Vision Insurance

Vision insurance is through Anthem. The plan pays benefits for network and out-of-network providers. However, when you see out-of-network providers the plan will reimburse charges up to an allowed amount and you are responsible for all costs over the allowed amount.

PLAN BENEFITS	Anthem Vison	
	In-Network	Out-of-Network
Copayments Exams Materials	$10 copay $25 copay	
Exams (every 12 months)	No charge after copay	Plan pays up to $45
Lenses (every 12 months) Single Vision Bifocal Trifocal	 No charge after copay No charge after copay No charge after copay	 Plan pays up to $30 Plan pays up to $50 Plan pays up to $65
Frames (every 12 months)	$200 allowance plus 20% off any charges above $200	Plan pays up to $110
Contacts (every 12 months) Elective	$200 allowance	Plan pays up to $105

The above information is a summary only. Please refer to your Evidence of Coverage for complete details

Basic Life and Accidental Death & Dismemberment Insurance – Included with your Coverage

A Life Insurance benefit of $25,000 will be paid to your designated beneficiary in the event of death while covered under the plan. The Accidental Death & Dismemberment benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Important Reminder!

Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes.

Short-Term Disability Insurance – Included with your Coverage

In the event you become unable to work due to a non-work-related illness or injury, this benefit covers 60% of your weekly base salary up to $3,000 per week and includes disability due to pregnancy and/or childbirth. The maximum covered annual salary is $260,000. The benefit begins after a 7 day waiting period and the duration may continue up to the date of eligibility for Long Term Disability. Please see the Benefit Summary for complete details

Long-Term Disability Insurance – Included with your Coverage

In the event you become unable to work due to a non-work-related illness or injury, this benefit covers 60% of your monthly base salary up to $12,500 per month. The benefit duration is for a maximum of 5 years. The maximum covered annual salary is $250,000. Long-Term Disability insurance is designed to pick up where Short-Term disability coverage ends. Please see the Benefit Summary and for complete details.

Employee Assistance Program – Included with your Coverage

The EAP can provide you and your family with guidance, focus, and support for a wide range of issues, such as personal, substance abuse, emotional stress, dependent care and work-related concerns. You can reach a specially trained counselor 24 hours a day for on the spot assistance. **All services are confidential**. See page 29 for more details.

Call Resource Advisor or reach them online:

1-888-209-7840
www.ResourceAdvisorCA.anthem.com
Program Name: ResourceAdvisor

Supplemental Life and Accidental Death & Dismemberment

You will have the opportunity to purchase Supplemental portable term life insurance of up to $1 Million plus an accompanying accidental death & dismemberment policy. You may also purchase life insurance for your spouse/domestic partner and children. Your Supplemental Life Insurance may be purchased in $10,000 increments up to $1Million. Spousal benefits are purchased in $5,000 increments up to 50% of your benefit, not to exceed $100,000 and child coverage caps at $10,000 per child. Your cost will depend on your age and the amount of coverage you elect. You will be required to submit a medical questionnaire and be approved for the coverage.

Anthem Voluntary Plans

The following are available at additional cost. Anthem is offering the three following voluntary plans which are 100% employee paid (post tax). Please see the Anthem sales information in the "Additional Resources" section for more information and the Summary of Benefits at PHBP.org for complete details.

- **Accident –** If you enroll in the accident plan, you may also purchase coverage for your spouse/domestic partner and dependent children. Benefits are paid as a lump-sum, the amount is determined by the type of injury caused by the accident. You decide how to use the benefit.

- **Critical Illness –** Provides a lump-sum benefit you can use to pay the direct and indirect costs related to any of the covered critical illnesses. The benefit amount is $20,000 for employees and dependents will be offered 50% of the employee benefit amount ($10,000). Health Screening Benefits are built into the plan and Anthem will pay a health screening benefit upon submission of proof.

- **Hospital Indemnity –** The Hospital Indemnity plan pays cash benefits, currently $1,000, directly to you when you're admitted to the hospital for an inpatient stay for covered services. Cover yourself or you and your dependents. There is an additional benefit, currently $200, payable for each day (they do not have to be consecutive) that you are confined to a hospital, for up to 31 days per year.

These coverages do not take the place of medical insurance.

See the following page for rates
**** All Benefit Summaries can be found at PHBP.org/documents ****

Supplemental Life and Voluntary Benefits Monthly Rates

SUPPLEMENTAL LIFE/AD&D		
SUPPLEMENTAL LIFE with AD&D		
***Rates per $1,000 of coverage	**Employee Rates**	**Spouse Rates**
Employee Age		
Under 25	$0.040	$0.082
25 - 29	$0.040	$0.082
30 - 34	$0.049	$0.093
35 - 39	$0.070	$0.129
40 - 44	$0.099	$0.264
45 - 49	$0.148	$0.425
50 - 54	$0.232	$0.776
55 - 59	$0.360	$1.517
60 - 64	$0.506	$2.478
65 - 69	$0.738	$2.478
70 +	$1.187	$4.578
		* Spouse rate based on EE age
Child	$0.212	
AD&D Rates		
Employee	$0.022	
Spouse	$0.022	
Child	$0.064	

Employee coverge can be purchased in $10,000 increments up to $1,000,000.
Spouse coverage can be purchased in $5,000 increments up to the lesser of $100,000 or 50% of employee coverage limit.
Child coverage can be purchased in $1,000 increments up to $10,000 per child.
Supplemental Life and Supplemental AD&D are a package and cannot be purchased separately.

ANTHEM VOLUNTARY BENEFITS				
ACCIDENT		**HOSPITAL INDEMNITY**		
Covered Members	**Rates**	**Covered Members**	**Rates**	
Employee	$7.79	Employee	$20.20	
Employee + Spouse	$12.24	Employee + Spouse	$42.12	
Employee + Child(ren)	$13.00	Employee + Child(ren)	$31.41	
Employee + Spouse/Child(ren)	$20.45	Employee + Spouse/Child(ren)	$54.80	
CRITICAL ILLNESS				
Attained Age	**Employee Only Rates**	**Employee + Spouse Rates**	**Employee + Child(ren) Rates**	**Employee + Spouse/Child(ren) Rates**
<25	$5.40	$8.60	$8.82	$12.56
25 - 29	$6.74	$10.62	$10.17	$14.58
30 - 34	$7.64	$12.15	$11.17	$16.11
35 - 39	$9.89	$15.69	$13.51	$19.66
40 - 44	$13.51	$21.98	$17.61	$25.94
45 - 49	$20.25	$33.51	$25.04	$37.47
50 - 54	$28.31	$47.02	$33.73	$50.98
55 - 59	$39.55	$66.22	$46.03	$70.18
60 - 64	$56.21	$94.48	$64.26	$98.45
65 - 69	$76.07	$127.36	$85.76	$131.32
70-74	$103.05	$170.36	$113.80	$174.32
75-79	$140.70	$227.67	$151.60	$231.63
80-84	$167.58	$269.00	$178.86	$272.96

Eligibility

Maintaining your Eligibility:

You are eligible for coverage in the Producers' Health Benefits Plans when you qualify by:

- Working 100 days per year ("day" defined as a minimum of 8 hours, "year" as 12 consecutive months) OR Earning $35,000 per year.
- Only non-union commercial work in a covered job category for PHBP participating employers counts towards eligibility.
- Music videos, TV, Features, webisodes, etc., are NOT included.
- You must re-qualify each year for continued coverage.
- Coverage begins the 1st of the month following a 60-day processing period after you attain eligibility or requalify for continued coverage. See the "Summary Plan Description" and the "Summary of Material Modifications" at phbp.org/documents for complete rules.

Open Enrollment Period:

For eligible freelancers, your open enrollment period is the 30-day period prior to the start of your next coverage period. **This is the only period of time in which you may make changes to your benefits and add or remove dependents.** Exceptions are made when there is a change in your Family Status. See below for details.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too, provided you properly enroll them and pay applicable contributions. In general, eligible dependents include your spouse, domestic partner and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court- appointed legal guardianship, as well as children of same sex state-registered domestic partners.

Proof of Dependent Status:

For your dependents to be eligible for coverage you must provide proof of dependent status at the time of enrollment. Below is a list of acceptable documents you will need to provide as proof of dependent status:

- **Spouse/Marriage:** Copy of your certified marriage certificate and most recent tax return if the marriage certificate was issued more than 1 year prior (you will also need to notify the Fund Office of other coverage for your Spouse or family, if applicable).

- **Domestic Partner:** Copy of your registered Declaration of Domestic Partnership and documents to support at least two of the following conditions as evidence of your financial interdependence:

  - Most recent Mortgage statement or Title showing joint ownership of a residence
  - Most recent Car loan statement or Title showing join ownership of an automobile
  - Most recent statement of a joint credit account
  - A lease for a residence identifying both partners as tenants
  - A will and/or life insurance policies which designates the other as primary beneficiary

- **Child/Birth**: Copy of your child's certified birth certificate showing the parents' names and a copy of the child's social security card.

- **Adoption or placement for adoption:** Copy of certified court order signed by a judge, copy of birth certificate and copy of social security card.

- **Stepchild:** Copy of certified birth certificate (if adopted, see above) showing your spouse or Domestic Partner as the biological/adoptive parent of the child and a marriage certificate and tax return between you (the Participant) and the child's parent (if stepchild's parent is your Domestic Partner, see above "Domestic Partner" for proof requirements) and copy of the child's social security card.

- **Child covered pursuant to a Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document signed by judge or National Medical Support Notice.

- **Disabled Dependent Child:** Current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically disabled, that disability existed before the attainment of age 26, that the child is incapable of self-sustaining employment as a result of that disability; and proof the child is dependent chiefly on you and/or your Spouse for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child including proof that the child is claimed as a Dependent for federal income tax purposes.

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation will be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in delay in your enrollment.

Annual Administrative Fee:

An annual administrative fee of $300 will be due upon enrollment and each renewal of enrollment. Failure to pay the required fee will result in the forfeiture of all benefits.

What if I don't requalify for continued coverage?

You must re-qualify each year for continued coverage. To help you reach the 100-day requirement we have "Banked Days" and "Bridge Payments'.

Banked Days –

- You can bank your worked days in excess of 100 per year for use in the upcoming qualifying year.
- The maximum number of banked days a freelancer can use toward eligibility is 50% of the total number of days needed for eligibility. For 2024, the requirement is 100 days so the maximum number of banked days a freelancer can apply is 50 days.
- Only qualifying workdays for Participating Employers can be banked.
- If the sum of your current qualifying days and your applicable banked days is 100 days worked or more, you qualify for policy renewal.

Bridge Payment –

- You can "bridge" the gap between your actual days worked and the 100 days of work needed to requalify by making monthly payments equal to $10.18 per each day needed to bridge the gap.
- Example: You have 20 days banked from your previous qualifying period and worked 48 days in the current qualifying period, for a total of 68 days. That's 32 days short of the 100 needed to re-qualify. The Bridge Payment would be 32 days x $10.18 per day, for a total of $325.76 per month.
- You may combine your actual workdays with applicable banked days from last year's qualifying period. The total of banked and worked days must be at least 50 days to be eligible for Bridge payments.
- While participating in the Bridge, the participants will pay the full cost of dependent coverage each month.
- Bridge payments can be made for up to 12 months, or until you re-qualify by earning $35,000 or working 100 days in a consecutive year.
- The $300 Annual Administrative fee due upon enrollment must be paid on a pro rata basis in the amount of $25 per month while "on the bridge". Once "off the bridge", the full administrative fee of $300 will be due upon enrollment in your next eligible 12 month Coverage Period.

How do I Enroll?

The PHBP is partnered with Synergy Enrollment & Benefits. Their online enrollment system, ***"Employee Navigator",*** will streamline the enrollment process for you. The services provided include scheduled, one-on-one phone consultations between you and a licensed benefits counselor to help choose which coverage is best for you and your family. There is also an online Cost Calculator to help you run the numbers and evaluate the costs of contemplated "buy ups", supplemental or Voluntary Benefits. Your benefits counselor can assist you with those calculations. If you are new to PHBP, returning after an absence, or adding dependents to continuing coverage, YOU MUST ENROLL OVER THE PHONE WITH A PHONE COUNSELOR. How to enroll and schedule a benefits consultation:

Call a Benefits Counselor - Counselors are available to answer questions and discuss your options. To schedule time to speak to a counselor:

- Call 858-282-0660, mention PHBP
- Click this link: https://synergynewhires.fullslate.com/services/348

Once your appointment is scheduled, you should prepare for the call by having beneficiary and dependent information with you: names, social security numbers and dates of birth.

Enroll Online - If you are renewing existing coverage with no change to your Plan **and** you are not adding dependents, you can go directly to the new enrollment system, *Employee Navigator,* and re-enroll or change beneficiaries online. If you do nothing, your current coverage will continue as is with no interruption.

- Go online to www.employeenavigator.com
- Click "Login" on the upper right-hand corner
- Click "Register as a new user"
- You will be asked for a "Company Identifier" which is FREELANCE

After Enrollment: Medical, Dental and Vision ID cards

- Anthem is the carrier for all of the above coverages. Anthem will only be providing ID cards to new adult members or those making plan changes.
- ID cards may take up to 60 days after the effective date of coverage to arrive by mail.
- You can also download a digital ID card or order replacement cards at Anthem.com/CA.
- You may use the Sydney Health mobile app to view your ID card or email it to your provider. See page 28.
- You may request ID Cards for your child dependents at Anthem.com/CA or by calling the Anthem customer service number on the back of your ID card.

Additional Resources

- **HSA Deposit Instructions and Worksheet -** Instructions on how to open and contribute to the HSA
- **Live Health Online -**Video visits with a board-certified doctor or licensed therapist
- **How to Find an Anthem Doctor -** Step by step instructions on how to find an Anthem provider
- **Sydney App -** Mobile app for employees enrolled in any of the Anthem medical plans. The App can help with locating an in-network doctor, check cost of care, see claims and much more.
- **Anthem Employee Assistance Program (EAP) -** Confidential support and guidance for everyday life
- **Anthem Maternity Disability**
- **Anthem Voluntary Accident, Critical Illness and Hospital Indemnity -** Product description

HSA Deposit Instructions

Congratulations on electing the PHBP High Deductible Health Plan ("HDHP"). The following are instructions on how to fund your Health Savings Account. Once Anthem has processed your election and enrolled you in the HDHP, they will automatically open your HSA bank account with WealthCare Saver (the account custodian) and mail a debit card and welcome letter to your home address.
You can fund your Health Saving Account (HSA) by Post-tax deposits.

If you don't receive your debit card or run into issues retrieving your HSA account number, call the Anthem customer service number located on your Anthem ID card.

Employee Post-tax Deposit

1. You can deposit money directly to your HSA and claim the deduction when you file your taxes.
2. Register or log in at Anthem.com/CA
3. Under "My Plans", select "Spending Accounts"
4. Click on "Manage My Account". Select "Contributions"
5. Click "Add Bank Account" and add your personal checking account information and follow all instructions.
6. Once the bank account is entered, select "Add Contribution" from the Contributions page and transfer money directly from your personal checking account into your Health Savings Account. These contributions are "Post-Tax" and can be deducted from your reported gross income when you file your taxes, reducing your income tax.

Make sure the grand total of all your contributions does not exceed the maximum allowed contribution for the year.

Health Savings Account (HSA) Payroll Deduction Form

WealthCare Saver Routing #075072157

Section A: Personal Information

Employer Name

First Name | Last Name

Last 4 digits of SSN or Employee ID

Email | Phone

HSA Account Number

Section B: Calculating Your Maximum HSA Contribution

Use this section to determine how much you can contribute

	Maximum allowed contribution for 2024*		Are you age 55 or older? *If NO, write $0 If YES, write $1,000*		How much your employer will contribute for the year		Total annual amount you can contribute
Individual	$4,150.00	+	_____	–	_____	=	_____
Family	$8,300.00	+	_____	–	_____	=	_____

**The IRS has established annual limits that can be contributed to a Health Savings Account.*

Section C: HSA Payroll Contribution Election

	Employee pre-tax payroll deduction amount to be contributed each pay period		Number of Pay Periods		Annual Election Amount
☐ Individual					
☐ Family	$_____	X	_____	=	$_____

Total may not exceed "total annual amount you can contribute" above.

NOTE: If you have previously contributed to an HSA via payroll deduction or directly to your account during the current plan year, you should track your annual contributions to ensure you do not exceed the annual maximum allowed.

The total of any previous or future pre-tax or post-tax contributions not reflected in this section, combined with your "Annual Election Amount" calculated above cannot exceed the "Total Contribution Amount"

Section D: Employee Authorization

I authorize the deduction from my salary on a per paycheck basis, by the amount designated in Section C as a pre-tax contribution to my Health Savings Account (HSA). I understand funds that are deducted from my pay and not used for eligible health care expenses incurred after my HSA account was established will be taxable in accordance with IRS regulations, and it is solely my responsibility to report these funds to the IRS.

Employee Signature _____ Date ____ / ____ / ____

See a doctor or therapist when it works for you

Using LiveHealth Online, any time works for a video visit with a doctor or therapist.

If you need care for a health issue, or support if you're feeling anxious or having trouble coping on your own, LiveHealth Online is ready to help. You can stay home and have a video visit with a board-certified doctor or licensed therapist on your smartphone, tablet or computer.

By using LiveHealth Online, you can

- **See a board-certified doctor in a few minutes with no appointment.** Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy.[1] When your own doctor isn't available, use LiveHealth Online if you have pinkeye, a cold, the flu, a fever, allergies, a sinus infection or another common health condition.
- **Make an appointment with a licensed therapist in four days or less.**[2] You can have a video visit with a therapist from home, at work or on the go — evenings and weekend appointments are available too. Appointments can be scheduled online or over the phone at **1-888-548-3432** from 7 a.m. to 7 p.m., seven days a week. You can get help for anxiety, depression, grief, panic attacks and more.

What will a visit cost?

Your Anthem plan includes benefits for video visits using LiveHealth Online, so you'll just pay your share of the costs — usually $59 or less for medical doctor visits, and a 45-minute therapy session usually costs the same as an office therapy visit.

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

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

Download on the App Store

ANDROID APP ON Google play

Anthem

LiveHealth ONLINE

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross.

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Anthem

Use the Find Care tool at anthem.com/ca to

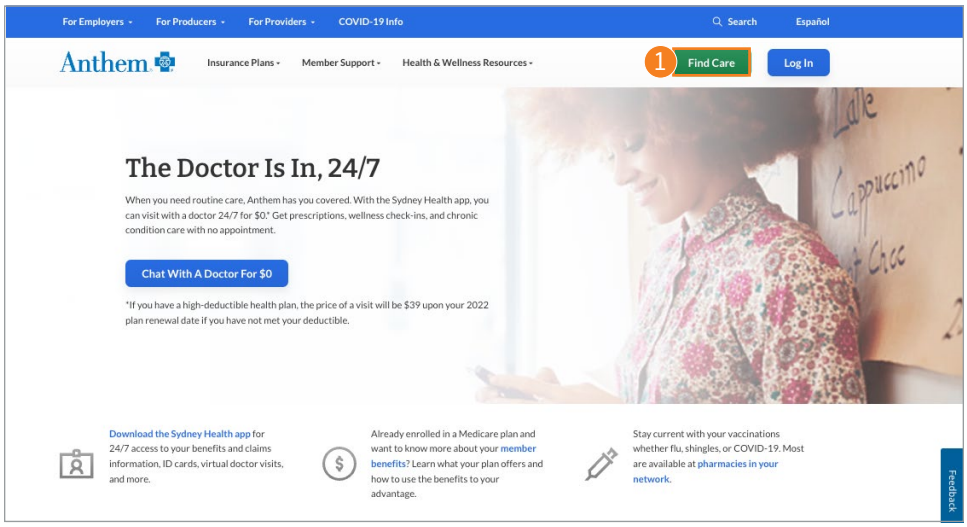
find the care you need

Anthem's Find Care tool was created to make it easy to find preferred primary care providers and specialists in your area. Whether you're searching for medical or dental use this quick step-by-step guide to help you find the best doctors where you live and work.

General search

Step 1

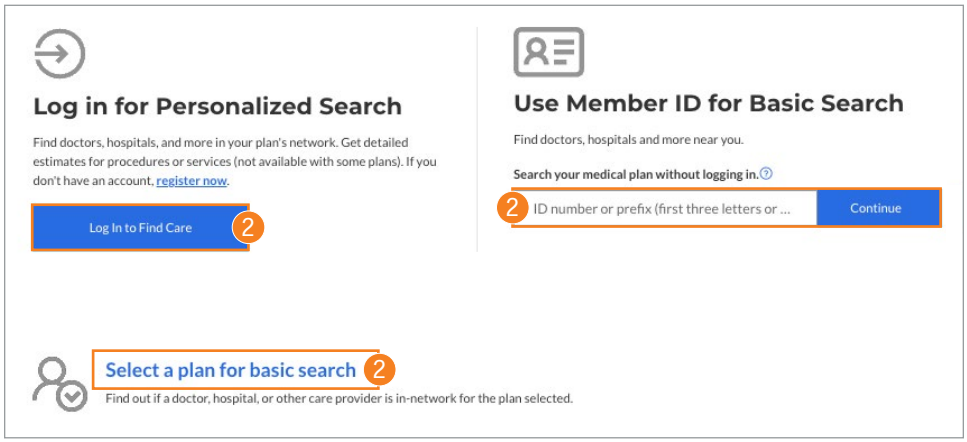
Go to: **anthem.com/ca** and select **Find Care** on the top right corner.



Step 2

There are three ways to search for a doctor:

1. Select **Log in for Personalized Search** and log in with your email address or username and password — you will be directed to your network of providers.
2. Under **Use Member ID for Basic Search**, input your member ID and you will be directed to your network of providers without logging in.
3. Click on **Select a plan for basic search** and answer four questions.



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Step 3

Select a plan for basic search:

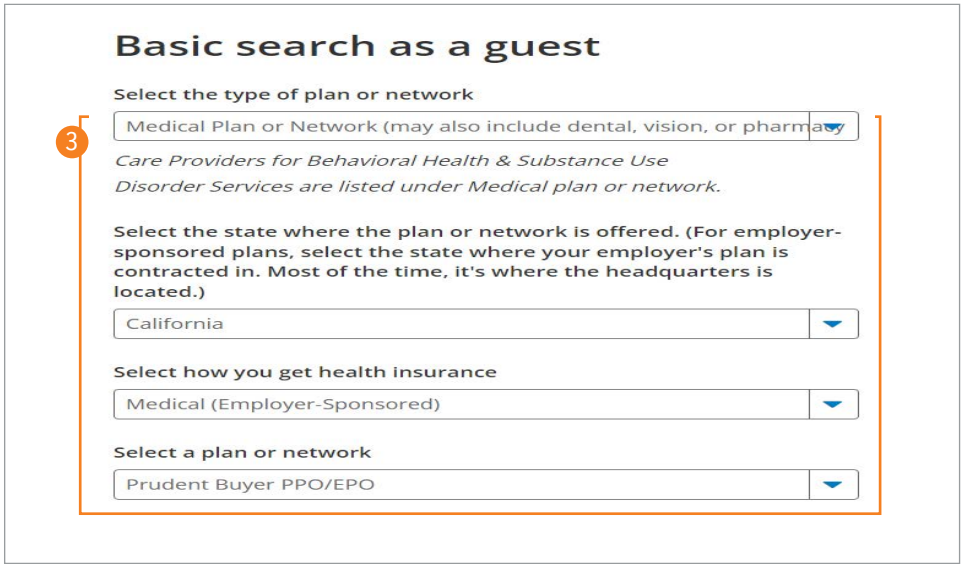
Select a drop-down box to answer each question.

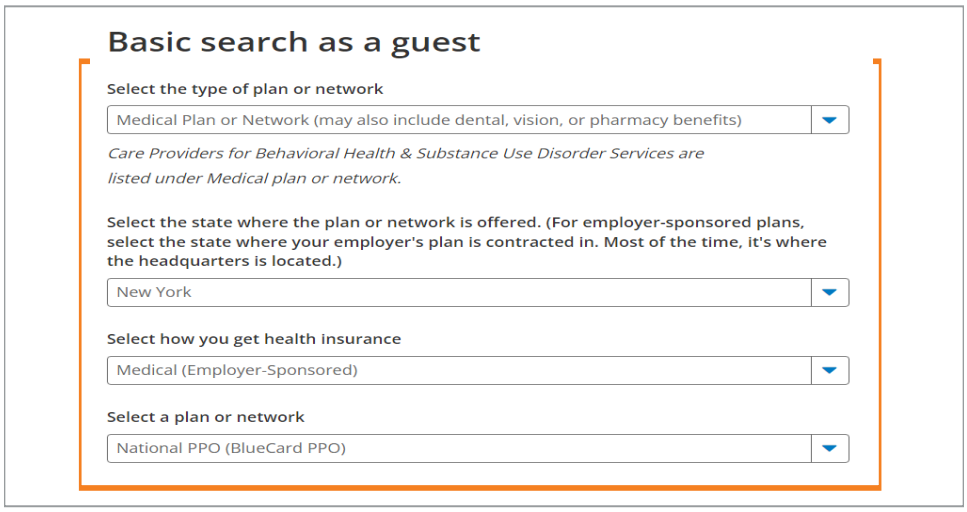
Answers to the dropdown questions:

What type of care are you searching for? Medical Plan or Network. (You can also select dental or vision providers from this drop-down)

What state do you want to search with? Select the state you live in.

What type of plan do you want to search with? Medical (Employer-Sponsored).





Select a plan/network

California PPO members - select the plan enrolled in:

- Prudent Buyer PPO/EPO

For out of California PPO members, select

- National PPO (BlueCard PPO)

Select a plan/network

California HMO members select:

- Blue Cross HMO (CACare) Large Group

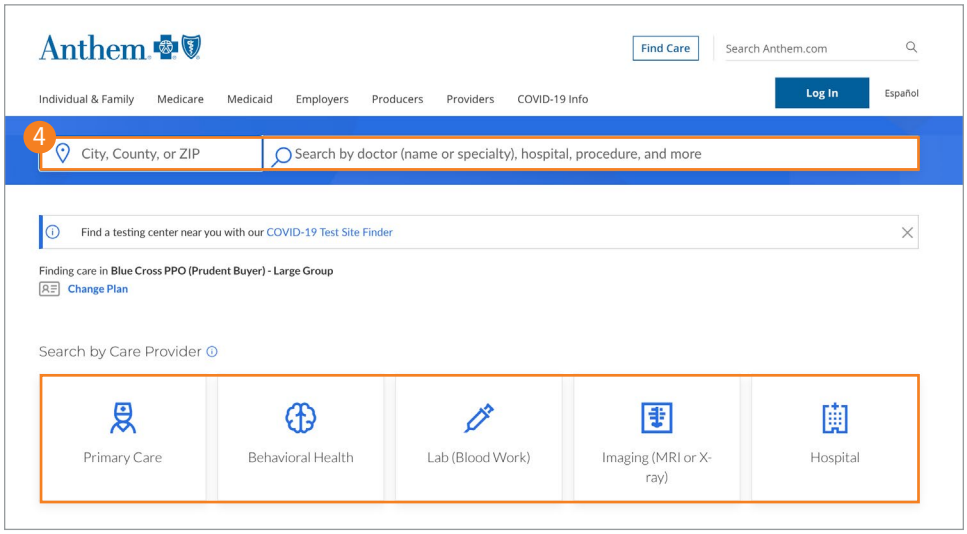
Once you've answered the four questions, select **Continue**.

Step 4

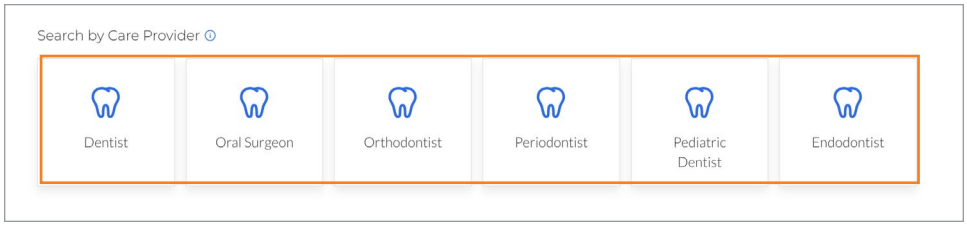
Search for care by entering:

- Your city, county, or ZIP code.
- Name or specialty, national provider identifier (NPI), or license number.
- You can also select the *Search by Care Provider* boxes listed in blue for frequently searched care options.

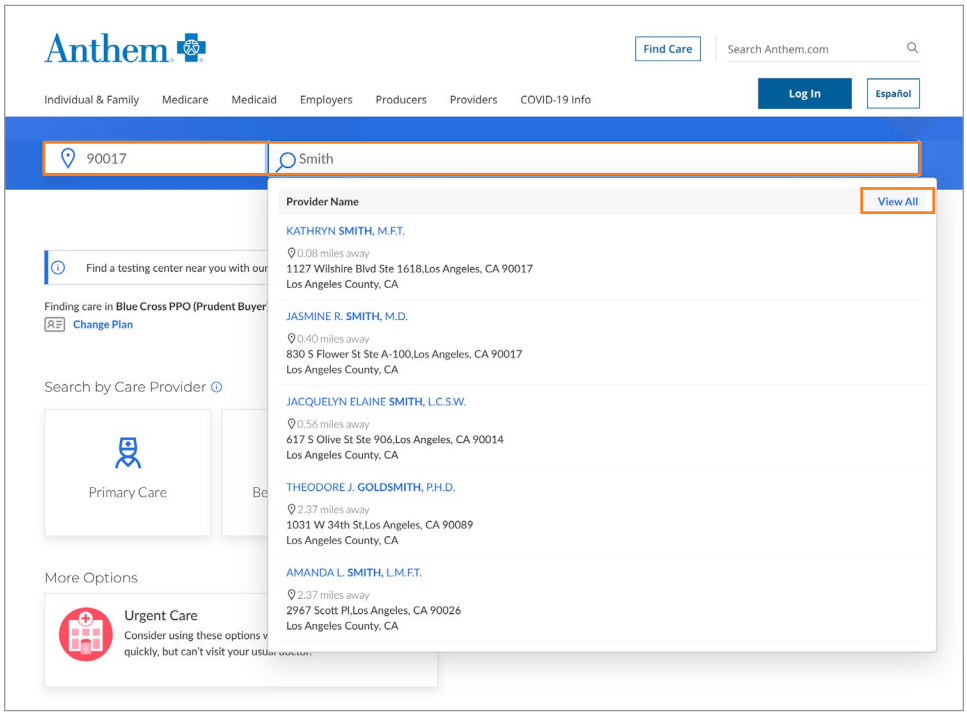
If you are looking for a **medical** provider:



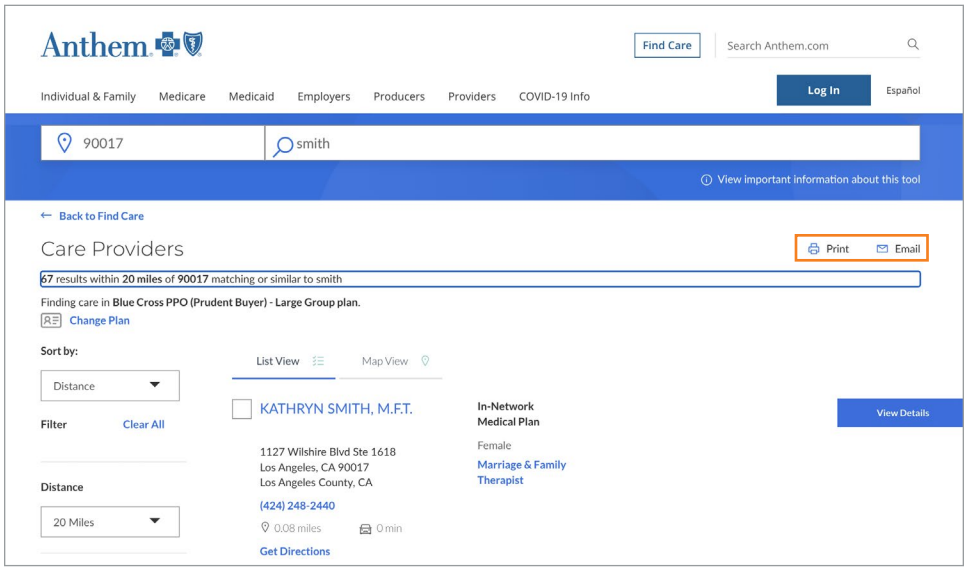
If you are looking for a **dental** provider:

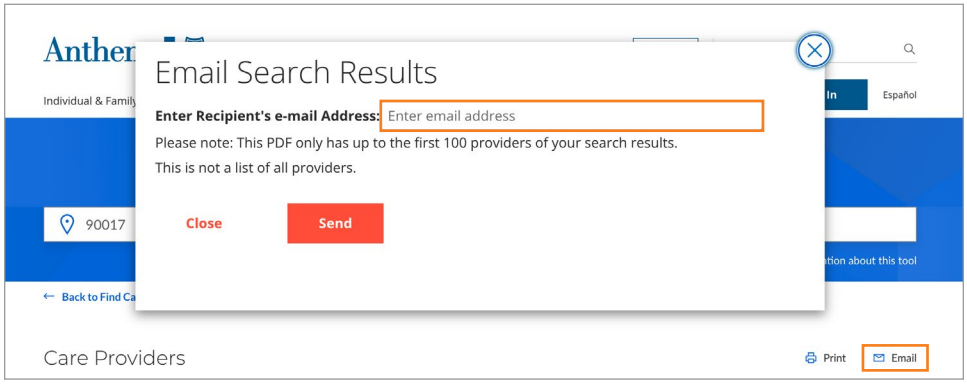


- If you enter a provider's name and your ZIP code, a list of providers will appear. To see a full list of providers with similar names, select **View All**.



- A list of providers will populate from your search. You can print it or email the list to your personal email.





Anthem

Anthem's Sydney Health app makes healthcare easier

Look up your personalized health and wellness information from anywhere

If you have an Anthem health plan, our Sydney℠ Health app can help you make the most of your benefits. Download and use the app to:

- View and use your **digital ID card**.
- Have a **video visit** with a doctor or mental health professional.[1,2]
- **See what's covered** and **check your claims**.
- **Locate care** nearby and **check the cost**.
- Look up your **health history and medical records** — and your family's — with My Health Records.
- Chat with **a live agent** to get answers to your healthcare questions.
- Discover **well-being tips** on your MyHealth Dashboard.
- Find organizations that can help you with **food, transportation, and child care**.

Customized tools to help you stay in good health

The Personalized Preventative Care Checklist uses your claims history to notify you when it's time for you to take preventive care action and helps you plan for future actions.

The Nutrition Tracker logs your meals and tracks your nutrition using food-scanning technology. It also helps you meal plan.

Download our Sydney Health app today!

sydney℠

Scan the QR code with your phone's camera or visit anthem.com/ca to use the same features on our website.

1 Appointments subject to availability of a therapist.

2 Online counseling is not appropriate for all kinds of problems. If you are in crisis or having suicidal thoughts, it's important that you seek help immediately. Please call 800-273-8255 (National Suicide Prevention Lifeline) or 911 for help. If your issue is an emergency, call 911 or go to your nearest emergency room. Emergency services are not provided on the Sydney Health app or anthem.com.

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

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Resource Advisor is here to help

Resource Advisor, a member assistance program that's included with your life and/or disability benefit, provides resources and services to support you and your household family members when you need it.

Counseling by phone, face-to-face or LiveHealth Online video chat

When you're feeling stressed, worried or having a tough time, you may want someone to talk to. You and your household family members can call Resource Advisor anytime, 24/7, and talk with a licensed counselor:

- **By phone**: Call **1-888-209-7840**.
- **In-person**: Call to set up face-to face sessions and then schedule with your counselor.
- **Video chat**: Talk with a counselor from the convenience of your home or wherever you have internet access and privacy using LiveHealth Online. To set up a LiveHealth Online visit, call Resource Advisor. We'll give you details about how to schedule a visit, along with a coupon code that gives you LiveHealth Online visits at no extra cost to you.

You can also review a therapist's background and qualifications to help choose one who's available and right for you. Whatever works for you — we're here to help with any concern, no matter how big or small.

You and your family members are eligible for up to three counselor visits for each issue or concern, at no cost to you.

Counselors can help with:

- Stress
- Financial concerns
- Anxiety and depression
- Legal issues
- Identity theft
- Help dealing with illness
- Relationship or family issues
- ID monitoring
- Child care and elder care

Resource Advisor
1-888-209-7840

www.ResourceAdvisorCA.anthem.com
(Log in with program name ResourceAdvisor.)

Support when you need it

Here are some services you can count on from Resource Advisor

Financial planning

Call Resource Advisor to set up one-on-one financial counseling with a certified professional financial planner. They can help with issues like retirement planning, saving for a child's education and more.

Legal services

With a call to Resource Advisor, you can get a consultation with an attorney over the phone at no charge. If you want to meet with an attorney in person, the legal consultant can set up an appointment at a discounted fee.

Identity theft recovery and monitoring

Resource Advisor has fraud resolution specialists who can help if your identity is stolen. They can work with creditors, collection agencies, law firms and credit reporting agencies for you for up to one year. You can sign up for ID monitoring, get credit report reviews and place fraud alerts on credit reports no matter how many times your identity is compromised.

Online tools to help with life's issues

The Resource Advisor website has tools to help with many of life's challenges, such as creating a will, parenting, aging, healthy living, household support, referrals, funeral planning and more. Visit www.ResourceAdvisorCA.anthem.com and use the program name "ResourceAdvisor" to access resources.

Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call **1-800-784-2433** (National Suicide Prevention Lifeline) or 911 and ask for help.

If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

Appointments subject to availability of a therapist.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross.

Note about eligibility: This program is for active employees and their household family members. All benefits end at retirement.

Resource Advisor services are not a part of the certificate, policy or trust agreement and do not modify any insured benefits. Resource Advisor additional services are provided based on negotiated agreements between the insurance company and certain service providers. Although the insurance company endeavors to make these services available to all policyholders and certificateholders as described, modifications to our agreements with service providers may require that services be periodically modified or terminated. Such modification or termination of services may be made based on cost to the insurer, availability of services, or other business reasons at the discretion of the insurer or service providers.

Cut out this wallet card and keep it with you when you travel.

Anthem

Resource Advisor

Get support, advice and resources, 24/7.

1-888-209-7840

www.ResourceAdvisorCA.anthem.com

Disability benefits can help protect your financial security after childbirth

Pregnancy can bring many surprises — both wonderful and challenging. While it's hard to plan for the unexpected, having disability benefits can help you approach delivery with peace of mind.

How to prepare for maternity leave with disability benefits

1. Contact your HR or Benefits team (HR/Benefits) to learn about your disability benefits.
2. File a short-term disability claim one to two months before going on leave: online at **myspecialtyappsanthem.com/claims/alic** or call us at **844-404-2111**. We'll hold the claim so it's ready when you go out on leave.*
3. When you stop working, a short-term disability case manager will reach out to you and HR/Benefits to share next steps. Short-term disability benefits usually cover at least six weeks for a vaginal delivery and eight weeks for a C-section.

More ways to prepare for your leave

Find help navigating parenthood

Your disability benefits also include access to Resource Advisor, which offers help and resources for navigating parenthood. Visit **ResourceAdvisorCA.anthem.com** and log in with program name **ResourceAdvisor**. With Resource Advisor, you can:

- Connect with a counselor by phone, video call, or in person.
- Have up to three **no-cost** counselor visits per issue.
- Receive advice on parenting, finding child care, and budgeting.

Know your return-to-work plan

- Leaves vary by state. Work with your HR/Benefits team and your absence/disability case manager to make sure you understand your leave options.
- HR/Benefits can help you complete paperwork and transition back into the workplace.

Secure your finances

- Disability benefits can help replace part of your income while you are unable to work.
- If you don't have life insurance, it may be a good time to consider it to protect your family. You have **up to 30 days** after your baby's delivery to add dependent life insurance.

Do you have questions about your disability benefits?

Contact your Disability Case Manager for more information or call us at **800-232-0113.**

*You will need documented health reasons to file a short-term disability claim or take an extended leave.

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Anthem

Voluntary Supplemental Health Plans

Accident coverage – protect yourself from the unexpected

We don't expect accidents, and most of us don't plan or budget for them. But when they happen, the costs can be overwhelming, even with medical coverage.

That's where accident protection can help. These special plans pay out a cash benefit in one lump sum if you or a covered family member is injured because of an accident. You decide how to use the benefits to best support your recovery. You can use accident coverage to help pay for:

- **Out-of-pocket medical costs**, such as ambulance fees, physical therapy, X-rays or crutches.
- **Daily expenses** like rent, food, transportation or help around the house.

40 MILLION
ER visits due to injuries each year[4]

$1,917
Average cost of an ER visit[5]

Connected benefits make things easier for you

If you have a medical plan and Accident benefits with us, we'll automatically let you know when you may have an eligible accident claim.

Key plan features

- Cash benefit is paid directly to you in a lump-sum, tax-free payment.
- Auto alerts let you know you may have an eligible claim.[1]
- No medical questions or exam needed to enroll.
- You can take your coverage with you even if you leave your employer.[2]
- No limitations for pre-existing conditions.[3]
- Coverage is available for yourself, your spouse and dependent children.

Anthem

1 Available when you have both medical and accident benefits with Anthem.
2 Not available in all states. Insured will only be able to continue coverage while the policy is in-force with the policyholder and the insured must pay premium if electing to continue coverage after leaving employer.
3 Covered accidents must occur after the effective date of coverage.
4 Centers for Disease Control and Prevention, National Center for Health Statistics. *National Hospital Ambulatory Medical Care Survey* (2014): cdc.gov/nchs/data/nhamcs/web_tables/2014_ed_web_tables.pdf.
5 Health Care Cost Institute. *2016 Health Care Cost and Utilization Report* (January 2018): healthcostinstitute.org.

Group Accident benefits provided by policy form SAI B XX18 P or state equivalent.

108933CAMENABC VPOD Rev. 6/19

Summary of Benefits

Accident 24 Hour Medium Plan
Producers' Health Benefits Plan

Anthem

Accident coverage provides a cash benefit in one lump sum if you or a covered family member is injured because of an accident. Use accident coverage to help pay for out-of-pocket medical costs, such as ambulance fees, physical therapy, X-rays or daily expenses like rent, food, transportation. This plan covers accidents that occur both at and outside of the workplace.

Key features:

- Cash benefit is paid directly to you in a lump-sum, tax-free payment.
- No medical questions or exam needed to enroll.
- You can take your coverage with you even if you leave your employer.[1]
- No limitations for pre-existing conditions.[2]

Convenience

We are here to help. To file a claim, start with the claim form available from your employer. Follow the instructions on the form to submit and contact the Anthem Supplemental Contact Center with any questions.

	Benefit	Payment Limitation	Amount
Hospital and emergency	Hospital admission	Once/accident within 90 days	$1,000
	Daily hospital confinement	Up to 365 days/lifetime (total daily and ICU)	$200
	Daily ICU confinement	Up to 30 days/accident (subject to 365 Days/lifetime)	$400
	Ambulance – air	Once/accident within 72 Hours	$1,000
	Ambulance – ground	Once/accident within 90 Days	$300
	Blood/plasma/platelets	Once/accident within 90 Days	$300
	Emergency room	Once /accident within 72 Hours	$100
	Diagnostic exam	Once/accident within 90 Days	$150
	Urgent care	Once /accident within 72 Hours	$150
	X-ray	Once/accident within 90 Days	$150
Follow-up care	Accident follow-up	Up to 3 treatments/accident within 90 days	$75
	Acupuncture	Up to 10 visits/accident within 365 days	$25
	Child care	Up to 30 days/accident while insured is confined	$25
	Chiropractic care	Up to 10 visits/accident within 365 days	$25
	Initial doctor office visit	Once/accident within 90 days	$75
	Lodging	Up to 30 nights/lifetime	$125
	Medical appliance	Once/accident within 90 days	$150
	Physical therapy	Up to 10 visits /accident within 90 days	$25
	Rehabilitation facility	Up to 15 days/lifetime within 90 days	$200
	Transportation	Up to 3 trips/accident	$300

	Benefit	Payment Limitation	Amount
Specified injury & surgeries	Abdominal/thoracic surgery	Once/accident within 90 Days	$1,000
	Arthroscopic surgery	Once/accident within 90 Days	$300
	Concussion	Up to 3 Concussions/year within 72 Hours	$200
	Emergency dental – crown	Highest benefit once/accident within 90 Days	$300
	Emergency dental – extraction	Highest benefit once/accident within 90 Days	$100
	Eye injury – object removal	Highest benefit once/accident within 90 Days	$150
	Eye injury – surgery	Highest benefit once/accident within 90 Days	$450
	Knee cartilage – with repair	Highest benefit once/accident within 12 Months	$750
	Knee cartilage – without repair	Highest benefit once/accident within 12 Months	$150
	Laceration – 2 to 6 inches	Highest benefit once/accident within 72 Hours	$150
	Laceration – 6-inch or greater	Highest benefit once/accident within 72 Hours	$300
	Ruptured disc	Once/accident within 365 Days	$750
	Tendon/ligament/rotator cuff – single	Highest benefit once/accident within 365 Days	$750
	Tendon/ligament/rotator cuff –two or more	Highest benefit once/accident within 365 Days	$1,000
Catastrophic	Coma (≥ 168 continuous hours)	Once/accident within 90 days	$10,000
	Burn – 2nd degree (≥ 34% of body surface)	Highest benefit once/accident within 72 Hours	$1,000
	Burn – 3rd degree (≥ 18 sq. in. of body surface)	Highest benefit once/accident within 72 Hours	$10,000
	Burn – skin graft (3rd-degree burn)	Once/accident.	25% of 3rd-degree burn benefit
	Home health care	Per Day, Up to 30 days/accident	$50
	Paralysis – quadriplegia	Highest benefit once/accident within 90 days	$50,000
	Paralysis – paraplegia	Highest benefit once/accident within 90 Days	$25,000
	Prosthesis – single	Highest benefit once/accident within 365 days	$750
	Prosthesis – 2 or more	Highest benefit once/accident within 365 Days	$1,500
Accidental death and dismemberment	Accidental death	- Within 90 days, payable once/accident - 50% benefit for covered spouse - 25% benefit for covered child(ren)	$50,000
	Common carrier death		$150,000
	Both hands or both feet		$50,000
	Sight - both eyes		$50,000
	Speech & hearing (both ears)		$50,000
	1 Hand & 1 foot		$50,000
	1 Hand/foot & sight of 1 eye		$50,000
	1 Hand or 1 foot		$25,000
	Sight – 1 eye		$25,000
	Speech or hearing (both ears)		$50,000
	Thumb & index finger (same hand)		$5,000
Dislocation schedule	Ankle, Foot Bones (Except Toes)	- Closed/Non-Surgical Dislocation benefit is 50% of open benefit shown - Benefit for dependent spouse or child(ren) are 100% of the amount shown - Incomplete dislocations and dislocation without anesthesia are 25% of the benefit shown - Multiple dislocations and fractures are payable up to 200% of the highest benefit	$1,400
	Collarbone – Acromio/Separation		$320
	Collarbone – Sternoclavicular		$500
	Elbow		$640
	Finger, Toe		$320
	Hip		$3,800
	Knee		$1,800
	Lower Jaw		$640
	Shoulder (Glenohumeral)		$1,400
	Wrist		$1,400
	Hand Bones (Except Fingers)		$640

	Benefit	Payment Limitation	Amount
Fractures schedule	Ankle	- Closed/non-surgical benefit is 50% of open benefit shown - Benefit for dependent spouse or child(ren) are 100% of the amount shown - Chip fracture is payable at 25% of the benefit shown - Multiple dislocations and fractures are payable up to 200% of the highest benefit	$1,800
	Foot Bones (Except Toes)		$1,800
	Coccyx		$500
	Collarbone/Clavicle Or Sternum		$1,800
	Finger, Toe		$320
	Forearm – Radius Or Ulna		$1,800
	Hip, Thigh/Femur		$4,000
	Kneecap/Patella		$1,800
	Lower Jaw/Mandible (Exc. Alv. Process)		$1,400
	Leg – Fibula Or Tibia		$2,200
	Nose, Facial Bones (Except Jaw Bones)		$640
	Pelvis (Except Coccyx)		$3,600
	Vertebrae – Processes		$640
	Rib		$500
	Shoulder Blade/Scapula		$1,800
	Skull – Depressed		$3,600
	Skull — Non-Depressed/Simple		$1,000
	Upper Arm/Humerus		$1,800
	Upper Jaw/Maxilla(Exc. Alveolar Process)		$1,400
	Vertebrae – Body		$3,600
	Wrist, Hand Bones (Except Fingers)		$1,800

1 Not available in all states. Insured will only be able to continue coverage while the policy is in-force with the policyholder and the insured must pay premium if electing to continue coverage after leaving employer.
2 Covered accidents or illness must occur after the effective date of coverage.

Members must be enrolled in comprehensive health benefits from a group health insurance plan, an employer sponsored plan, an HMO plan, or an individual health plan that provides essential health benefits.

Group Accident benefits provided by policy form SAI B XX18 P or state equivalent.
This is not a contract; it is a partial listing of benefits and services. All covered service are subject to the conditions, limitations, exclusions, terms and provisions of your policy. In the event of a discrepancy between the information in this summary and the policy, your policy will prevail. If you have any questions, please contact your Human Resources/Benefits manager.

010123 Ver. 4/2019

Critical Illness coverage – easing the stress when illness strikes

When you have a critical illness, such as a heart attack or cancer, you want the best care. At times like these, you shouldn't have to worry about how you're going to pay for it. Critical Illness coverage provides the added layer of security you want and need — a lump-sum cash benefit to help pay for unexpected costs. You decide how to use the benefits to best support recovery for yourself or a family member.

You can use the lump-sum payment to help pay for:

- **Out-of-pocket medical costs**, such as doctor bills, imaging or rehab.
- **Daily expenses** like rent, food, transportation, childcare or help around the house.

Our Critical Illness coverage provides benefits for heart attack, stroke, invasive cancer, major organ transplant and neurological conditions such as advanced Alzheimer's and advanced Parkinson's. The coverage pays for the first diagnosis of certain illnesses after your coverage becomes effective. It may also cover a new cancer diagnosis even with a previous cancer diagnosis.[1]

Key plan features

- **Cash benefit is paid directly to you** in a lump-sum, tax-free payment.
- Auto alerts let you know you may have an eligible claim.[2]
- A $50 payment toward health screenings, such as a lipid test. Simply call the claim line and tell them you'd like to collect on your wellness benefits. We'll confirm your testing, then send you a check.
- No limitations on pre-existing conditions.[3]
- Coverage is available for yourself, your spouse and dependent children.
- You can take your coverage with you even if you leave your employer.[4]

Connected benefits make things easier for you

If you have a medical plan and Critical Illness benefits with us, we'll automatically let you know when you may have an eligible critical illness claim.

Anthem®

1 Restrictions may apply.
2 Available when you have both medical and critical illness benefits with Anthem.
3 Covered accidents or illness must occur after the effective date of coverage.
4 Not available in all states. Insured will only be able to continue coverage while the policy is in-force with the policyholder and the insured must pay premium if electing to continue coverage after leaving employer.

Group Critical Illness benefits provided by policy form SAI B XX18 P or state equivalent.

108934CAMENABC VPOD Rev. 6/19

Summary of Benefits

Critical Illness $20,000 Plan

With Skin Cancer benefit .

Producers' Health Benefits Plan

Anthem

Critical Illness coverage provides the added layer of security you want and need when illness occurs— a lump-sum cash benefit to help pay for unexpected costs. You decide how to use the benefits to best support recovery for yourself or a family member. Use your critical illness coverage to help pay for out-of-pocket medical costs, such as for prescriptions, hospital bills, X-rays or daily expenses like rent, food or transportation.

Key features:

- Cash benefit is paid directly to you in a lump-sum, tax-free payment.
- $50 payment towards health screenings, such as a lipid panel or fasting glucose test. .
- You can take your coverage with you even if you leave your employer.[1]

Convenience

We are here to help. To file a claim, start with the claim form provided by your employer. Follow the instructions on the form to submit and contact the phone number listed on that form with any questions about your benefits or about how to file a claim.

Note: Critical Illness benefits for covered spouse and dependents are 50% of the amount shown below, except for Health Screening, which is $50 for any covered member, and Skin Cancer, which is $250 for any covered member.

	Benefit	Amount
Cancer	Invasive cancer	$20,000
	Non-invasive cancer	$5,000
	Benign brain tumor	$20,000
Vascular	Heart transplant	$20,000
	Heart attack (myocardial infarction)	$20,000
	Stroke	$20,000
	Coronary artery by-pass surgery	$20,000
Other Specified Illness	Coma	$20,000
	Paralysis	$20,000
	Major organ transplant	$20,000
	End-stage renal disease	$20,000
	Loss of hearing	$20,000
	Loss of speech	$20,000
	Loss of vision	$20,000
Neurological	Advanced Parkinson's disease	$20,000
	Advanced Alzheimer's disease	$20,000
	Amyotrophic Lateral sclerosis	$20,000
	Advanced Multiple Sclerosis	$20,000
Childhood Conditions	Cystic Fibrosis	$10,000
	Muscular Dystrophy	$10,000
	Cerebral Palsy	$10,000
	Spina Bifida	$10,000
	Congenital Heart Disease	$10,000
		5
	Health screening benefit: per member, per calendar year	$50
	Skin Cancer benefit, per member, once per lifetime	$250
Recurrence benefits	Recurrence waiting period	12 months
	Invasive cancer	50% of previously covered benefit
	Benign brain tumor	50% of previously covered benefit
	Heart transplant	50% of previously covered benefit
	Heart attack (myocardial infarction)	50% of previously covered benefit
	Stroke	50% of previously covered benefit
	Coma	50% of previously covered benefit
	Major organ transplant	50% of previously covered benefit

Other Key Features	Additional occurrence of multiple conditions	Covered with 30-day separation period if both conditions are vascular or both are cancer. Otherwise, covered with no separation period.
	Lifetime benefit maximum — employee	$500,000
	Lifetime benefit maximum — spouse & children	$250,000

1 Not available in all states. Insured will only be able to continue coverage while the policy is in-force with the policyholder and the insured must pay premium if electing to continue coverage after leaving employer.
2 Covered accidents or illness must occur after the effective date of coverage.

Group Critical Illness benefits provided by policy form SCI B XX18 P or state equivalent.
This is not a contract; it is a partial listing of benefits and services. All covered service are subject to the conditions, limitations, exclusions, terms and provisions of your policy. In the event of a discrepancy between the information in this summary and the policy, your policy will prevail. If you have any questions, please contact your Human Resources/Benefits manager. If you have any questions, please contact your Human Resources/Benefits manager.

010123 Ver.5/2019

Hospital Indemnity coverage – protect your financial well-being

Hospital stays are never the same. Yet whether they are planned or unexpected, long or short, the costs can quickly add up. Some of the costs may be covered by your medical plan, but you can expect to pay some of the costs out of pocket. Protect yourself from these unexpected expenses with Hospital Indemnity insurance.

Hospital Indemnity provides a lump-sum, tax-free cash benefit to help pay for costs that can come with a hospital stay that your health plan doesn't cover. Think of it as a bit of financial assistance when you need it most.

You can use the lump-sum payment however you want. You might use it to help pay for out-of-pocket medical costs related to a hospital stay such as hospital bills, medical tests or rehab due to accident or illness. Or you might choose to use it for daily expenses like rent, food, transportation, childcare or help around the house.

Connected benefits make things easier for you

If you have a medical plan and Hospital Indemnity benefits with us, we'll automatically let you know when you may have an eligible indemnity claim.

Key plan features

- Covers hospitalization for normal pregnancy from day one with no waiting period.
- Auto alerts let you know you may have an eligible claim.[1]
- No limitations for pre-existing conditions.[2]
- No medical questions or exam needed to enroll.
- You can take your coverage with you and keep the same rate if you leave your employer, for up to three years.[3]
- Coverage is available for yourself, your spouse and dependent children.

43 MILLION
Americans have medical debt[4]

$30,000
Average cost of a 3-day hospital stay[5]

$41,878
Average cost of a hospital stay for a heart valve disorder[6]

1 Available when you have both medical and indenmity benefits with Anthem.
2 Covered accidents or illness must occur after the effective date of coverage.
3 Not available in all states. Insured will only be able to continue coverage while the policy is in-force with the policyholder and the insured must pay premium if electing to continue coverage after leaving employer.
4 Consumer Financial Protection Bureau Consumer Credit Reports - A Study of Medical and Non-medical collections (December 2014): consumerfinance.gov.
5 Healthline. *How Much Does it Cost to Stay in the Hospital?* (July 17, 2017): healthline.com.
6 U.S. Centers for Medicare & Medicaid Services. *Protection from High Medical Costs* (accessed May 2, 2018): healthcare.gov.

Anthem®

Group Hospital Indemnity benefits provided by policy form SAI B XX18 P or state equivalent.

108935MUMENABS VPOD Rev. 6/19

Summary of Benefits

Hospital Indemnity Plan

High Plan with Intensive Care Benefits

Producers' Health Benefits Plan

Hospital Indemnity provides a lump-sum, tax-free cash benefit to help pay for costs that can come with a hospital stay that your health plan doesn't cover. Use your hospital indemnity coverage to help pay for out-of-pocket medical costs or daily expenses like rent, food or transportation.

Key features:

- Cash benefit is paid directly to you in a lump-sum, tax-free payment.
- Covers hospitalization for maternity from day one with no waiting period.
- You can take your coverage with you even if you leave your employer for up to three years.[1]
- No limitations for pre-existing conditions.[2]

Convenience

We are here to help. To file a claim, start with the claim form provided by your employer. Follow the instructions on the form to submit and contact the phone number listed on that form with any questions about your benefits or about how to file a claim.

Benefit	Amount
Hospital confinement — first-day benefit	$1,000
Hospital confinement — daily benefit	$200
Intensive care unit confinement — daily benefit	$200
First-day hospital confinement — annual maximum	1 day
Daily hospital confinement — annual maximum	31 days
Daily intensive care unit confinement — annual maximum	31 days
Pre-existing conditions limitation	None
Maternity benefit waiting period	None

1 Not available in all states. Insured will only be able to continue coverage while the policy is in-force with the policyholder and the insured must pay premium if electing to continue coverage after leaving employer.
2 Covered accidents or illness must occur after the effective date of coverage.

Group Hospital Indemnity benefits provided by policy form SHI B XX18 P or state equivalent.
This is not a contract; it is a partial listing of benefits and services. All covered service are subject to the conditions, limitations, exclusions, terms and provisions of your policy. In the event of a discrepancy between the information in this summary and the policy, your policy will prevail. If you have any questions, please contact your Human Resources/Benefits manager.

010123 Ver. 5/2019

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

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

NEWBORNS ACT DISCLOSURE - FEDERAL

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

PATIENT PROTECTION MODEL DISCLOSURE

Anthem California Classic HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Anthem designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem.

For children, you may designate a pediatrician as the primary care provider.

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

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants. No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 per day (up to a $1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
BeneSys Administrators
P.O. Box 2340
West Covina, CA 91793
855-696-2909 extension 8604
Email: Staff@phbpbenefits.org

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.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

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
- Get a copy of this privacy notice
- 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
- Administer your health plan
- 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 actions

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, usually 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.

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 up to 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 at the end of this notice.
- 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/.**
- We will not retaliate against you for filing a complaint.

Your Choices

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

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.

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.

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: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- 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
We can use or share health information about you:
- 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: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

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

Other Instructions for Notice

- Effective Date of this Notice: 1/1/2024
  BeneSys Administrators
  P.O. Box 2340
  West Covina, CA 91793
  855-696-2909 extension 8604
  Email: Staff@phbpbenefits.org

Important Notice from Producers' Health Benefits Plan 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 Producers' Health Benefits Plan 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. **Producers' Health Benefits Plan has determined that the prescription drug coverage offered by the Anthem is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare 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, your current Producers' Health Benefits plan coverage will not be affected. You can keep this coverage and it will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Producers' Health Benefits Plan coverage, be aware that you and your dependents will be able to get this coverage back during open enrollment or in the case of a special enrollment opportunity.

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 Producers' Health Benefits Plan 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 Producers' Health Benefits Plan 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:	1/1/2024
Name of Entity/Sender:	Producers' Health Benefits Plan
Contact--Position/Office:	BeneSys Administrator
Address:	P.O. Box 2340, West Covina, CA 91793
Phone Number:	855-696-2909 extension 8604

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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 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)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
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: 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/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – 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	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: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Name Producers' Health Benefits Plan c/o BeneSys Administrators	4. Identification Number (EIN) 31-6654730	
5. Address P.O. Box 2340	6. Phone number 855-696-2909 extension 8604	
7. City West Covina	8. State California	9. ZIP code 91793
10. Who can we contact about employee health coverage? BeneSys Administrators		
11. Phone number (if different from above)	12. Email address Staff@phbpbenefits.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:
Refer to PHBP

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:
Refer to PHBP

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Contact Information

COVERAGE	CARRIER	PHONE NUMBER	WEBSITE
Benefit Administrator	BeneSys	(855) 696-2909 Ext. 8604 8 a.m. – 4 p.m. PST	Email: Staff@phbpbenefits.org
Benefit Counselors	Synergy Enrollment & Benefits	(858)282-0660	To schedule an appointment: https://synergynewhires.fullslate.com/services/348
Online Enrollment	Employee Navigator		www.employeenavigator.com
Medical HMO and PPO	Anthem	(800) 759-3030	www.anthem.com/ca
Medical HSA	Anthem	(844) 860-3535	www.anthem.com/ca
Dental PPO	Anthem	(877) 567-1804	www.anthem.com/ca
Vision	Anthem	(877) 635-6403	www.anthem.com/ca
Life and AD&D	Anthem	(800) 552-2137	Email: lifeclaims@anthem.com
Short Term Disability (STD)	Anthem	(800) 232-0113	Email: disability@anthem.com
Long Term Disability (LTD)	Anthem	(800) 232-0113	Email: disability@anthem.com
Employee Assistance Program	Anthem	(888) 209-7840	www.ResourceAdvisorCA.com Login Name: ResourceAdvisor

This brochure summarizes the benefit plans that are available to Producers' Health Benefits Plan eligible participants and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request. Information provided in this brochure is not a guarantee of benefits.