BENEFITS OVERVIEW

Prepared by Kraus-Anderson Insurance

PLAN YEAR: 2024/2025

Address
1380 Energy Lane, Suite 108
St. Paul, MN 55108

Phone
Main: 651-478-4535

Online
Website: www.newcenturyschool.net

WELCOME NOTE

At New Century School, we are committed to providing you with a comprehensive employee benefits program that helps our employees stay healthy, feel secure, and maintain a work and life balance.

PLAN YEAR: July 1, 2024 through June 30, 2025

EXISTING EMPLOYEES

Please review the benefit materials and make your coverage elections through EASE during your scheduled open enrollment period.

NEW HIRES

As part of your on-boarding, you'll need to select your benefits through your online benefits program called EASE. You must enroll online during this time in order to receive benefits.

ELIGIBILITY

- 30 hours per week
- Coverage goes into effect on the first of the month following 30 days of employment

ELIGIBLE DEPENDENTS

- Legally married spouse
- Child(ren) up to age 26

QUALIFYING LIFE EVENTS

IRS regulations restrict your ability to change your elections during the year unless you experience a qualifying life event such as:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a dependent
- Changes in your or your spouse's employment status
- Losing coverage from parent's plan at age 26
- An involuntary loss of coverage under another plan

You have **30 days** from the date of the qualifying event to make changes to your coverage, as long as the changes are consistent with the qualifying life event. Be sure to notify your plan administrator, then you will be provided the opportunity to make your changes using the EASE enrollment portal. You can make changes to your HSA contributions at any time during the year—you just can't exceed the annual limits.

CONTACTS

	INSURANCE CARRIER	CARRIER INFORMATION	PLAN INFORMATION
	MEDICAL: Medica	952-945-8000 www.medica.com Click here to find provider	Group Numbers: Copay Plan - 50242 HSA Plan Single - 50243 HSA Plan Family - 50247 Network: Passport
	PHARMACY: Medica	952-945-8000 www.medica.com Register here to find pharmacy	Rx Group: 1Medica Rx PCN: A4 Rx BIN: 003858
	HEALTH SAVINGS ACCOUNT (HSA): Further by HealthEquity	800-859-2144 www.hellofurther.com Register here	Group Number: 013889
	TELE-MEDICINE: HealthiestYou by Teladoc	866-703-1259 www.healthiestyou.com Register here	Group Number: HY9690
	DENTAL: Lincoln Financial	800-423-2765 www.lfg.com Click here to find provider	Group Number: 1131258
	VISION: MetLife	800-942-0854 www.metlife.com Click here to find provider	Group Number: 05369951
	LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D): Lincoln Financial	800-423-2765 www.lfg.com Member Login	Group Number: 1131258
	SHORT-TERM & LONG-TERM DISABILITY: Lincoln Financial	800-423-2765 www.lfg.com Member Login	Group Number: 1131258
	PLAN ADMINISTRATOR: Deema Sorri	651-478-4535	business@newcenturyschool.net

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.

MEDICAL

Plan Options	$1,000-$40-25% Passport Network		$2,500-0% HSA Passport Network	
	Individual	Family	Individual	Family
Deductible Calendar Year	$1,000	$3,000	$2,500	$5,000
Preventive Care www.healthcare.gov for covered screenings	No charge		No charge	
Coinsurance	25% after deductible		0% after deductible	
Out of Pocket Maximum	$4,250	$8,500	$2,500	$5,000
Office Visit	Primary care: $40 copay Specialist care: $40 copay Virtual care: $25 copay		0% after deductible	
Prescription Drug Coverage	Tier 1: $5 copay Tier 2: $60 copay Tier 3: $150 copay		0% after deductible	
	Check member services for pharmacies within your network			
Plan Cost	**Total Monthly Premium**	**Employee Monthly Premium**	**Total Monthly Premium**	**Employee Monthly Premium**
Employee	$687.42	$103.11	$669.72	$100.46
Employee + Spouse	$1,890.44	$1,134.26	$1,841.74	$1,105.04
Employee + Child(ren)	$1,306.10	$783.66	$1,272.46	$763.48
Family	$2,096.82	$1,258.09	$2,042.82	$1,225.69

HEALTH SAVINGS ACCOUNT (HSA)

2024 Maximum Contributions	2025 Maximum Contributions
Individual: $4,150 per calendar year	Individual: $4,300 per calendar year
Family: $8,300 per calendar year	Family: $8,550 per calendar year
55+ may contribute an additional $1,000 per calendar year	55+ may contribute an additional $1,000 per calendar year
Eligible Expenses: Please refer to section 213(d) of the Internal Revenue Code, can be found at www.irs.gov	

TELE-MEDICINE – HEALTHIESTYOU

- Employer contributes 100% of the premium
- 24/7 General Medical
- Unlimited Mental Health
- Dermatology
- Expert Medical Services (second opinions)
- Nutrition
- Back and Neck Care
- All employees enrolled in medical coverage will automatically receive HealthiestYou at no cost

DENTAL

New Century School contributes 65% to the employee's monthly premiums. Eligible dependents may participate in the plan and those costs are the responsibility of the employee.

Dental	Lincoln Financial	
Network	**In Network**	**Out of Network**
Individual Deductible	$25	$50
Family Deductible	$75	$150
Annual Maximum (per person)	$2,000	$1,500
Preventive Services	100%	100%
Basic Services	80%	60%
Major Services	50%	50%
Orthodontia Services (dependent children ages 8-18)	$2,000 Lifetime Maximum	$1,500 Lifetime Maximum
Plan Cost	**Total Monthly Premium**	**Employee Monthly Premium**
Employee Only	$32.97	$11.54
Employee + 1	$65.92	$44.49
Family	$127.23	$105.80

VISION

Coverage is voluntary and 100% paid by the employee.

Vision	MetLife (In-Network)
Eye Examinations (every 12 months)	$10 copay
Frames (every 12 months)	$150 allowance + 20% off remaining balance
Lenses (every 12 months)	$10 copay
Contacts (every 12 months)	$130 allowance
Members can receive benefit for either glasses OR contacts in a 12-month period, not both.	
Plan Cost	**Total Monthly Premium**
Employee Only	$12.13
Employee + Spouse	$24.33
Employee + Child(ren)	$20.59
Family	$33.95

LIFE AND AD&D (ACCIDENTAL DEATH & DISMEMBERMENT)

- Employer contributes 100% of the premium
- $50,000 life and accidental death dismemberment benefit
- Age reduction schedule applies, see Carrier booklet
- Refer to the carrier summary for specific details

VOLUNTARY LIFE AND AD&D

- Coverage is Voluntary and 100% of paid by employee
- Guarantee Issue (available upon initial enrollment only):
  - Employee: $150,000
  - Spouse: $50,000
  - Dependent Children: $10,000
- Evidence of insurability is required if exceeding the guaranteed issue amount for underwriting approval
- Benefit can be purchased in increments:
  - Employee: $10,000 increments, not to exceed 5 times your annual earnings or $500,000 maximum
  - Spouse: $5,000 increments, up to $100,000 (cannot exceed 50% of employee's benefit)
  - Dependent Children (1 – 14 days): $2,000
  - Dependent Children (14 days – 25 years): $2,000, $4,000, $8,000, $10,000, $20,000
- Age reduction schedule applies, see Carrier booklet
- Refer to the carrier summary for specific details

DISABILITY

	Short Term Disability	Long Term Disability
Elimination period	7 days for accident 7 days for illness 1 day if hospitalized	90 days of disability
Percentage of Income Replaced	60% of weekly income	60% of monthly income
Maximum Benefits Payable	$1,250 per week	$5,000 per month
Maternity Maximum Duration	6 weeks for normal delivery 8 weeks for c-section (Includes elimination period)	N/A
Maximum Benefit Duration	13 weeks	Own occupation: 2 years Any occupation: to Social Security Retirement Age
Pre-existing Conditions	N/A	If an insured becomes disabled in the first twelve months of coverage, the claims team will do a pre-existing diagnosis investigation three months prior to the individual's effective date.
Benefit Taxability	Benefit is not taxable	Benefit is not taxable

VOLUNTARY METLAW

- Provides consultation with an attorney in person or over the phone
- For more information: Please visit infolegalplans.com and enter access code GETLAW or call the client service center at 800-821-6400 (Monday – Friday, 8 am to 7 pm EST/EDT).

ADDITIONAL INFORMATION AND SERVICES

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.Medica.com or call 1-952-945-8000 (Minneapolis/St. Paul Metro area) or 1-800-952-3455. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-952-3455 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** per person / **$3,000** per family in-network and **$7,500** per person / **$22,500** per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, copayments, lab services, hospice and prescription drugs from in-network providers or well child and prenatal care from out-of-network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,250** per person / **$8,500** per family in-network. **$15,000** per person / **$30,000** per family for out-of-network services.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), health care this plan doesn't cover, out-of-network deductible and coinsurance.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/FindCare or call 1-952-945-8000 or 1-800-952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** $40 copay/visit. Deductible does not apply. **Chiropractic:** $40 copay/visit. Deductible does not apply. **Retail Health:** $25 copay/visit. Deductible does not apply. **Virtual:** $25 copay/visit. Deductible does not apply.	**Primary:** 50% coinsurance **Chiropractic:** 50% coinsurance **Retail Health:** 50% coinsurance **Virtual:** 50% coinsurance	In-network primary care visits provided at an outpatient facility may be subject to coinsurance and deductible. Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	$40 copay/visit. Deductible does not apply.	50% coinsurance	In-network specialist visits provided at an outpatient facility may be subject to coinsurance and deductible.
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance Deductible does not apply. **Other services:** 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** No charge. Deductible does not apply. **X-ray:** No charge. Deductible does not apply.	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Medica.com/DrugCost1	Generic drugs	**Retail:** $5/prescription. Deductible does not apply. **Mail order:** $15/prescription. Deductible does not apply.	50% coinsurance	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed $0 per retail prescription unit. Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect. ACA preventive drugs covered at no charge. Deductible does not apply.
	Preferred brand drugs	**Retail:** $60/prescription. Deductible does not apply. **Mail order:** $180/prescription. Deductible does not apply.	50% coinsurance	
	Non-preferred brand drugs	**Retail:** $150/prescription. Deductible does not apply. **Mail order:** $450/prescription. Deductible does not apply.	50% coinsurance	
	Specialty drugs	**Preferred:** 25% coinsurance. No more than $500 copay/prescription. **Non-Preferred:** 45% coinsurance. Deductible does not apply.	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. Amounts reimbursed or paid by a provider or manufacturer, on your behalf for a product or service, will not apply toward your cost share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	In-network deductible and out-of-pocket applies.
	Emergency medical transportation	25% coinsurance	25% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	$40 copay/visit. Deductible does not apply.	$40 copay/visit. Deductible does not apply.	In-network out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/visit. Deductible does not apply.	50% coinsurance	Coinsurance may apply for some in-network outpatient services such as intensive outpatient programs.
	Inpatient services	25% coinsurance	50% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge. Deductible does not apply.	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. certain ultrasounds.)
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	$40 copay/visit. Deductible does not apply.	50% coinsurance	120 visits in-network and 60 visits out-of-network per member per year.
	Rehabilitation services	$40 copay/visit. Deductible does not apply.	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	$40 copay/visit. Deductible does not apply.	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	25% coinsurance	50% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	25% coinsurance	50% coinsurance	None
	Hospice services	25% coinsurance. Deductible does not apply.	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% coinsurance	None
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services.)

- Acupuncture exceeding 15 visits per member per year for in-network and out-of-network acupuncture services combined
- Bariatric surgery
- Chiropractic care exceeding 15 visits per member per year out-of-network
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Glasses
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care except for specified conditions
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602 or the U.S. Department Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan administrator or you may contact Medica at 1-800-952-3455.

Does this Plan Provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Plan Meet the Minimum Value Standard? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-952-3455.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-952-3455.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-952-3455.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-952-3455.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$45
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,270**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$45
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,300**

Mia's Simple fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$45
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

Note: The amount the patient pays assumes the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as deductibles, copayments, coinsurance, and benefits otherwise not covered.

This self-funded group health plan is sponsored by your employer and administered by Medica Self Insured (MSI).
The plan would be responsible for the other costs of these EXAMPLE covered services.

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

اذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍ ທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.Medica.com or call 1-952-945-8000 (Minneapolis/St. Paul Metro area) or 1-800-952-3455. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-952-3455 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500** per person / **$5,000** per family in-network and **$13,000** per person / **$26,000** per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, preventive prescriptions and prenatal care from in-network providers or well child and prenatal care from out-of-network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$2,500** per person / **$5,000** per family in-network. **$20,000** per person / **$40,000** per family for out-of-network services.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), health care this plan doesn't cover, out-of-network deductible and coinsurance.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/FindCare or call 1-952-945-8000 or 1-800-952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** 0% coinsurance **Chiropractic:** 0% coinsurance **Retail Health:** 0% coinsurance **Virtual:** 0% coinsurance	**Primary:** 50% coinsurance **Chiropractic:** 50% coinsurance **Retail Health:** 50% coinsurance **Virtual:** 50% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance Deductible does not apply. **Other services:** 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** 0% coinsurance **X-ray:** 0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Medica.com/DrugCost2	Generic drugs	**Preventive:** Designated preventive drugs: No charge. Deductible does not apply. **Retail:** 0% coinsurance **Mail order:** 0% coinsurance	50% coinsurance	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed $0 per retail prescription unit. Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect. ACA preventive drugs covered at no charge. Deductible does not apply.
	Preferred brand drugs	**Preventive:** Designated preventive drugs: No charge. Deductible does not apply. **Retail:** 0% coinsurance **Mail order:** 0% coinsurance	50% coinsurance	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	**Preferred:** 0% coinsurance **Non-Preferred:** Not covered	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. Amounts reimbursed or paid by a provider or manufacturer, on your behalf for a product or service, will not apply toward your cost share.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	Emergency medical transportation	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	**Prenatal care:** No charge. Deductible does not apply. **Postnatal care:** 0% coinsurance	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. certain ultrasounds.)
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	120 visits in-network and 60 visits out-of-network per member per year.
	Rehabilitation services	0% coinsurance	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	0% coinsurance	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	0% coinsurance	50% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	0% coinsurance	50% coinsurance	None
	Hospice services	0% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% coinsurance	None
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services.)

- Acupuncture exceeding 15 visits per member per year for in-network and out-of-network acupuncture services combined
- Bariatric surgery
- Chiropractic care exceeding 15 visits per member per year out-of-network
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Glasses
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care except for specified conditions
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602 or the U.S. Department Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan administrator or you may contact Medica at 1-800-952-3455.

Does this Plan Provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Plan Meet the Minimum Value Standard? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-952-3455.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-952-3455.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-952-3455.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-952-3455.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,200**

Mia's Simple fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

Note: The amount the patient pays assumes the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as deductibles, copayments, coinsurance, and benefits otherwise not covered.

This self-funded group health plan is sponsored by your employer and administered by Medica Self Insured (MSI).
The plan would be responsible for the other costs of these EXAMPLE covered services.

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

اذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

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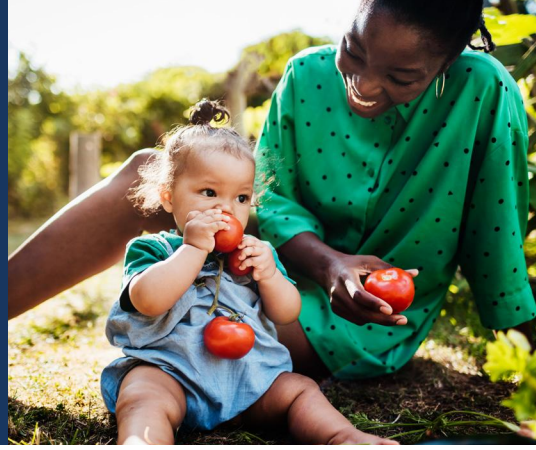
COMIFB-0119-I

My Health Rewards by Medica®



Your healthier future starts now

The My Health Rewards online tool and app lets you log healthy habits, track activity through a fitness tracker, and complete other healthy activities to earn rewards. Rewards can be redeemed as e-gift cards and health and fitness products. You can also choose to donate your rewards to a charitable cause.

Sign up today

Follow these easy steps to create an account once your plan year starts. Already have an account? Sign in on the Virgin Pulse app or at **Medica.com/MHC**.

Contract Holders:

1. Download the free Virgin Pulse app from the App Store or Google Play.
2. Open the app and click on "Create Account" under the "Sign In" button.
3. Search for and choose **Minnesota Healthcare Consortium** on the sponsor organization list.
4. Follow the steps to sign up. Enter your name exactly as it appears on your Medica ID card.

Prefer to sign up online? Go to **Medica.com/MHC** to create your account.

Spouses and dependents ages 18+:

1. Download the free Virgin Pulse app from the App Store or Google Play.
2. Open the app and click on "Create Account" under the "Sign In" button.
3. Search for and choose **Medica My Health Rewards** on the sponsor organization list.
4. Follow the steps to sign up. Enter your name exactly as it appears on your Medica ID card.

Prefer to sign up online?
Go to **Medica.com/MHC** to create your account.

Assess your health

Keeping up with preventive care keeps you feeling your best. First, go to the "Health" tab to complete your health assessment. Then, "My Care Checklist" gives you personalized, friendly reminders that let you know when you're due to see your health care provider. Earn points by tracking your preventive care screenings and visits. You'll even earn a bonus $5 reward each year when you complete your annual health checkup (just enter the date in "My Care Checklist").

Connect your fitness tracker

Earn points by connecting your fitness tracker and apps to track your activity, sleep, calories, and more. For a full list of compatible trackers, go to "Devices & Apps" in the "More" section.

1. Go to "Devices & Apps" in the "More" section
2. Choose the device or app you'd like to connect
3. Follow the on-screen instructions

Personalize your health journey

Go to "Topics of Interest" under the "More" section to choose topics you're interested in: eating healthy, sleeping well, reducing stress, and more. You'll get daily learning cards with helpful tips. Do some of them, and you'll earn points toward rewards!

Medica | Minnesota Healthcare Consortium
Participating Minnesota Service Cooperatives

Choose the tools and programs that work for you

Get rewarded for using tools and Medica programs that can help improve your overall well-being. Go to the "Benefits" page and click "View All" to learn more about them.

Earn points, get rewards

1 Go to the "Rewards" page 2 Click on "Learn How to Earn More Points" 3 See a list of all the ways you can earn

A monthly statement, also under the "Rewards" page, gives you a summary of the points you've earned. Your points add up throughout the year.

WAYS TO EARN	POINTS	PULSECASH REWARD AMOUNT	REWARD TYPE
EARN PROGRAM POINTS	2,000	$10	E-gift card or other options
	10,000	$20	E-gift card or other options
	25,000	$50	E-gift card or other options
	40,000	$80	E-gift card or other options
		$160 per year	
20-DAY TRIPLE TRACKER	Track* any combination of the following activities on 20 or more days in a calendar month to earn a bonus reward: • 7,000 steps a day and/or; • 15 active minutes a day and/or; • 15 workout minutes a day.	Contract Holders: $15 per month Spouses/ dependents ages 18+: $5 per month	E-gift card or other options
PREVENTIVE CHECKUP	Complete your annual preventive checkup and earn a bonus reward. Go to My Care Checklist in the Health tab and enter your preventive checkup completion date.	$5 per year	E-gift card or other options
Point-based rewards + 20-day triple tracker + preventive checkup =		$345 in potential rewards per year (Contract Holders) $225 in potential rewards per year (Spouses/dependents ages 18+)	

**You must connect your fitness tracker to your My Health Rewards account. Manual tracking of steps and active minutes will not count toward earning the monthly reward.*

Go to the mobile app or sign in to your account at **Medica.com/MHC** to get started.

Have questions? We're here to help.

Medica.Support@VirginPulse.com or **1 (833) 450-4074**. Use the Chat button if you're using a web browser.

My Health Rewards is not available with all Medica plans. Medica reserves the right to modify the program requirements and devices at any time. Participation in a wellness program is optional. Rewards are available to all eligible employees that participate. If you think you might be unable to meet a standard for a reward under this wellness program, you may qualify for an opportunity to earn the same reward by different means. Email **Medica.Support@VirginPulse.com** or call Virgin Pulse at **1 (833) 450-4074** for information on available reasonable alternative standards and we will work with you (and, if you wish, your physician) to find a wellness activity with the same reward that is right for you in light of your health status.

Medica

LIFE TIME® DIGITAL FITNESS PROGRAM

Live healthy — anytime, anywhere

Unlock a healthier you with the **Life Time® Digital fitness program** at no extra cost. The Life Time Digital app provides access to hundreds of on-demand and live fitness classes, meditations, plus nutrition and lifestyle articles to support your well-being goals.

App highlights:

- Over 500 weekly classes led by top instructors
- Exercise anytime, anywhere, with live streaming and on-demand cardio, strength, yoga, and more
- Expert-designed coaching programs covering nutrition, exercise, strength, recovery, and healthy habits
- Discover the benefits of guided meditation with hundreds of hours of support led by a dedicated team of mental health experts
- Expert-curated, evidence-based resources are just a tap away, covering physical, mental, spiritual, and social aspects of a healthy life

The Life Time Digital membership is not available with all Medica plans. If your coverage with Medica ends, you have the option to cancel or continue your Life Time Digital membership. If you continue, you are responsible for the monthly membership cost.

New year, new journey

Beginning January 1, 2024, follow these four simple steps to enroll:

1. Log in to your member account at **Medica.com/SignIn**
2. Select "**Programs + Tools**" under the "**Wellness**" section in the navigation menu
3. Under "**Life Time Digital**," click "**Sign up**"
4. Once you've signed up for your Life Time Digital account, download the Life Time Digital app from the Apple Store or Google Play to begin your journey

LIFE TIME | Available on the App Store | GET IT ON Google Play

Have questions? We're here to help.

Call Member Services at the number on the back of your Medica ID card **(TTY: 711)** or find answers to commonly asked questions in your member account at **Medica.com/SignIn**.

Medica

Virtual Care

Save time, connect with a provider online

Virtual care, also known as online care or an e-visit, is a convenient way to get care for many common conditions. Connect with a provider from your computer or mobile device to get a diagnosis, treatment plan, and prescription (if needed).

Virtual care may be a time-saving option for common conditions like:

- Allergies
- Bladder infections
- Bronchitis
- Colds and coughs
- Ear pain
- Flu
- High blood pressure
- Migraines
- Pink eye
- Rashes
- Sinus infections

With a virtual care visit, you:

- Avoid a trip to the doctor's office and get care from the comfort of your home, work, or wherever you are
- Initiate the visit at your convenience — no appointment needed
- Get care when you need it — visits are often available after clinic hours, sometimes even 24/7
- May save money — a virtual care visit can cost less than a regular visit to the doctor's office, depending on your plan

To check your plan's coverage for behavior health, sign in to your secure member website at **Medica.com/SignIn** or call the number on the back of your Medica ID card.

SAVE TIME

- Connect with a provider online
- Get help for many common conditions

VIRTUAL CARE OPTIONS

- Many clinics let you connect with your provider online
- Amwell (**Amwell.com/cm**)
- Virtuwell® (**Virtuwell.com**)

See the back for more information.

Medica

Virtual care options

You can access virtual care through providers in your plan's network. Check your virtual care options at **Medica.com/FindaDoctor**. Your virtual care options may include:

YOUR CLINIC	HOW IT WORKS
Many clinics offer virtual care, online care, or e-visits. Visit **Medica.com/FindaDoctor** to see which clinics in your plan's network offer virtual care services.	Check with your clinic to see if it offers virtual care and how you can connect with your provider online.

AMWELL

amwell

Amwell is a 24/7 online clinic available in every state.

Services:

- Treatment of common medical conditions. Each visit is $64 or less, depending on your plan's coverage for virtual care.
- Behavioral health care services, including therapy and psychiatry. Cost per visit may vary depending on your plan and type of service. Eligible services are covered under your plan as a behavioral health office visit.*
- Amwell also offers other online services, but it's not an in-network provider for them. You can use those services, but you'll pay the full cost.

HOW IT WORKS

You have a video visit with a board-certified doctor or nurse practitioner using the web or mobile app.

1. To get started, create an Amwell account:

   Smartphone/tablet: Download the free Amwell app from the App Store or Google Play
   Computer: Go to **Amwell.com/cm**
   Phone: Call **(844) 733-3627**
2. Enter your email address, create a password, then add the requested insurance information from your Medica ID card.
3. Select a doctor or nurse practitioner and follow the prompts to start your visit.
4. The provider will review your history, answer questions, diagnose, treat, and prescribe medication (if needed).
5. If you need a prescription, it'll be sent to your pharmacy. The cost of your prescription will be based on your plan's prescription drug coverage.

VIRTUWELL

virtuwell

Virtuwell is a 24/7 online clinic available in select states.**

Virtuwell is not an in-network provider for the following plan networks: Altru and You with Medica℠, Clear Value with Medica℠ and VantagePlus with Medica℠.

Services:

- Treatment of common medical conditions. Check the virtuwell website for current pricing. Visits are typically $59 or less, depending on your plan's coverage for virtual care.

HOW IT WORKS

You have an online visit with a certified nurse practitioner.

1. Go to **Virtuwell.com** and take a quick online interview that checks your medical history and makes sure your problem can be treated online.
2. If you can be treated online, you'll create an account with your contact, insurance, pharmacy, and payment information.
3. A nurse practitioner will review your case and write a personalized treatment plan. You'll get an email or text when your plan is ready.
4. If a prescription is needed, it'll be sent to your pharmacy. The cost of your prescription will be based on your plan's prescription drug coverage.

*To check your plan's coverage for behavior health, sign in to your secure member website at **Medica.com/SignIn** or call the number on the back of your Medica ID card.

**Visit Virtuwell.com for a list of available states.

Medica

HealthEquity® | HSA

Health Savings Account

An Health Savings Account (HSA) lets you put money away for future healthcare costs while saving on taxes. How? HSAs are never taxed at a federal income tax level when used for qualified medical expenses. Contributions can come straight out of your paycheck, and your HSA can grow tax-free too.

- ☑ No 'use-it-or-lose-it,' keep your HSA forever
- ☑ Create a healthcare emergency safety net
- ☑ Invest[1] your HSA tax-free, like a 401(k)

Annual tax saving potential[2]

$1,660
Family plan

$830
Individual plan

2024 IRS Contribution Limits	
$8,300 Family plan	**$4,150** Individual plan
Members 55+ can contribute an extra $1,000	

See how much you can save

HealthEquity.com/Learn/HSA

Common qualified medical expenses:

- Pain relievers
- Doctor visits
- Dental cleaning
- Sleep aids
- Eyeglasses/contacts
- Cold/cough medicine
- Chiropractic care
- Insulin testing supplies

[1]Investments made available to HSA members are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. | [2]Estimated savings are based on an assumed combined federal and state income tax rate of 20%. Actual savings will depend on your taxable income and tax status. | HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

healthiestyou By Teladoc

Virtual care that makes healthier possible

Access your healthcare by phone, video or app.

General Medical (24/7 Care)

Need care for non-urgent and common conditions? Get a same-day appointment with a certified clinician from wherever you are.

Expert Medical Opinion

Need a second opinion? Get assurance and advice on a diagnosis, treatment or surgery from leading experts in over 450 specialties.

Mental Health

Have real conversations and see progress with a therapist or psychiatrist of your choice. Available 7 days a week from the privacy of your own home.

myStrength by Teladoc Health

Discover digital content and resources based on your goals and needs. Recommended activities and content. Explore skill building tools and resources based on your ongoing needs and preferences.

Digital Physical Therapy

Overcome pain from home, in partnership with Sword Health, through a custom plan from a physical therapist and personalized content.

Dermatology

Start an online skin review with a dermatologist by uploading images and details of your concern. Get a treatment plan and prescription if needed in 24 hours or less.

Nutrition

Members work directly with registered dietitians who assess clinical nutrition needs and develop personalized programs including custom meal plans and shopping guides

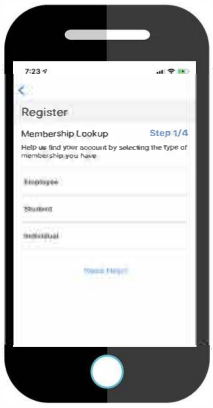
Set up your account or log in to schedule a visit

Visit HealthiestYou.com | Call 1-866-703-1259 | Download the app

How to register and get started with HealthiestYou!

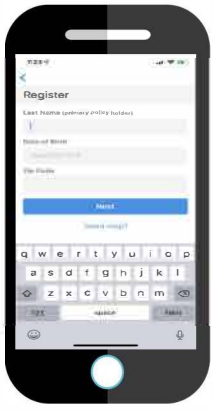
Step 1

- Search and download "HealthiestYou" or "HY" in the app store or Google Play! Available on your iPhone or Android devices!



Step 2

- Select "First time here? Register Now". Select employee as your membership type.



Step 3

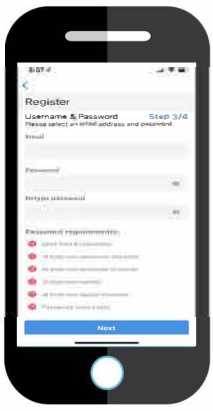
Enter the Primary Member's Information:

- Last Name
- D.O.B.
- Zip Code

Step 4

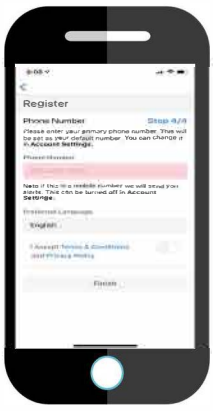
A list of names associated with the account will appear. Select your name.

- **Dependents under 18 will appear on the primary member's profile.**
- **Dependents over 18 will need to register their own account with a separate email.**



Step 5

- Enter in a valid email address and password.
- Password must meet the listed requirements.



Step 6

Enter in the best number to reach you. Our doctors will use this number to contact you.

- Select your preferred language. Click "I Accept Terms & Conditions."
- Click Finish.

Download the App Today!

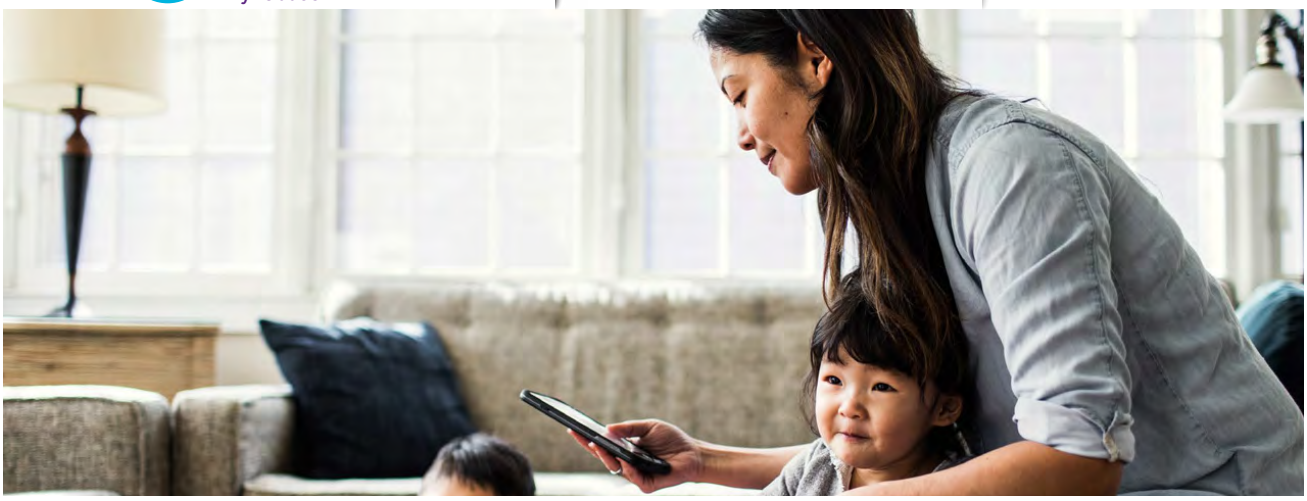
member.healthiestyou.com

Need A Doctor? 866-703-1259 x1

Account Help? 866-703-1259 x3

healthiestyou By Teladoc

Be your Healthiest You



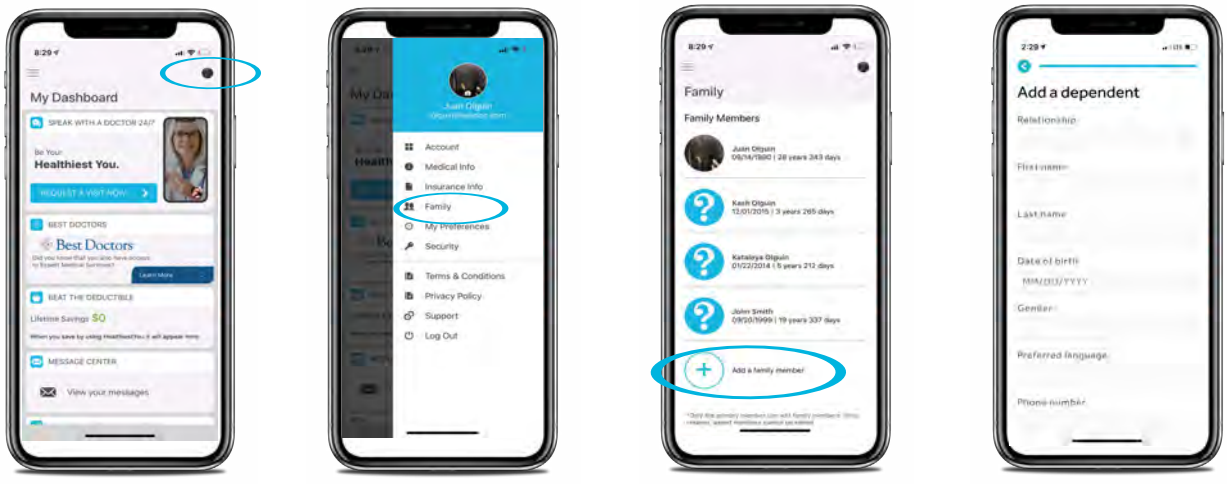
Links to 'How To' Videos

Adding Family - App Adding Family - Website

Adding your Dependents Through the HY mobile app.

1. **Open the "HealthiestYou" app** and select the icon in the **upper right hand corner.**
2. **Select "Family".** The app will show display the names of anyone listed on your account.
3. **Select "Add a Family member"** to add a Spouse/Dependent that is not listed.
4. **Complete the required fields.** Once saved, your Spouse/Dependent will now be able to register their own mobile app profile.

Spouses and dependents over the age of 18, must register their own account using a separate email.



NOTE: Any Spouse/Dependent that is added, will need to wait 24 hours to become effective.

Set up your account today

HealthiestYou.com | 866-703-1259

Lincoln Financial Group®

All Full-Time Employees of New Century School

Benefits At-A-Glance

Dental Insurance

The *Lincoln DentalConnect®* PPO Plan:

- Covers many preventive, basic, and major dental care services
- Also covers orthodontic treatment for children
- Features group coverage for New Century School employees
- Allows you to choose any dentist you wish, though you can lower your out-of-pocket costs by selecting a network provider
- Does not make you and your loved ones wait six months between routine cleanings

	In-Network	Out-of-Network
Calendar (Annual) Deductible	Individual: $25 Family: $75 Waived for: Preventive	Individual: $50 Family: $150 Waived for: Preventive
Deductibles are combined for basic and major In-Network services. Deductibles are combined for basic and major Out-of-Network services.		
Annual Maximum	$2,000	$1,500
Annual Maximums are combined for preventive, basic, and major services.		
Lifetime Orthodontic Max	$2,000	$1,500
Orthodontic Coverage is available for dependent children.		
Waiting Period	There are no benefit waiting periods for any service types	

Visit LincolnFinancial.com/FindADentist

You can search by:

- Location
- Dentist name or office name
- Distance you are willing to travel
- Specialty, language and more

Your search will automatically provide up to 100 dentists that most closely match your criteria. If your search does not locate the dentist you prefer, you can nominate one—just click the **Nominate a Dentist** link and complete the online form.

Preventive Services	In-Network	Out-of-Network
Routine oral exams Bitewing X-rays Full-mouth or panoramic X-rays Other dental X-rays (including periapical films) Routine cleanings Fluoride treatments Space maintainers for children Sealants	100% No Deductible	100% No Deductible
Basic Services	**In-Network**	**Out-of-Network**
Problem focused exams Palliative treatment (including emergency relief of dental pain) Injections of antibiotics and other therapeutic medications Fillings Prefabricated stainless steel and resin crowns Simple extractions Biopsy and examination of oral tissue (including brush biopsy)	80% After Deductible	60% After Deductible
Major Services	**In-Network**	**Out-of-Network**
Consultations Simple extractions Surgical extractions Oral surgery General anesthesia and I.V. sedation Prosthetic repair and recementation services Endodontics (including root canal treatment) Non-surgical periodontal therapy Periodontal surgery Bridges Full and partial dentures Denture reline and rebase services Crowns, inlays, onlays and related services TMJ Implants & implant related services	50% After Deductible	50% After Deductible
Orthodontics	**In-Network**	**Out-of-Network**
Orthodontic exams X-rays Extractions Study models Appliances	50%	50%

In-Network/Out-of-Network Dentists	In-Network	Out-of-Network
To find an in-network dentist near you, visit www.LincolnFinancial.com/FindADentist. This plan lets you choose any dentist you wish. However, your out-of-pocket costs are likely to be lower when you choose an in-network dentist. For example, if you need a crown…	…you pay a deductible (if applicable), then 50% of the remaining discounted fee for PPO members. This is known as a PPO contracted fee.	… you pay a deductible (if applicable), then 50% of the maximum allowable charge (MAC) which is the maximum expense covered by the plan. You are responsible for the difference between the maximum allowable charge and the dentist's billed charge.

With the Lincoln Dental Mobile App

- Find a network dentist near you in minutes
- Have an ID card on your phone
- Customize the app to get details of your plan
- Find out how much your plan covers for checkups and other services
- Keep track of your claims

Lincoln DentalConnect® Online Health Center

- Determine the average cost of a dental procedure
- Have your questions answered by a licensed dentist
- Learn all about dental health for children, from baby's first tooth to dental emergencies
- Evaluate your risk for oral cancer, periodontal disease and tooth decay

Covered Family Members

When you choose coverage for yourself, you can also provide coverage for:

- Your spouse.
- Dependent children, up to age 26.

Benefit Exclusions

Like any coverage, this dental coverage does have some exclusions.

- The plan does not cover services started before coverage begins or after it ends. Benefits are limited to appropriate and necessary procedures listed in the summary plan description. Benefits are not payable for duplication of services. Covered expenses will not exceed the summary plan description's allowances.
- Plan benefits are not payable for a condition that is covered under Workers' Compensation or a similar law; that occurs during the course of employment or military service or involvement in an illegal occupation, felony, or riot; or that results from a self-inflicted injury.
- The plan does not cover an orthodontia treatment plan started before coverage begins unless the member was receiving orthodontia benefits from the employer's previous group dental summary plan description. In this case, Lincoln Financial will continue orthodontia benefits until the combined benefit paid by both policies is equal to this summary plan description's lifetime orthodontia maximum. Plan benefits are not payable if the orthodontic appliance was installed after the age of 19.
- In certain situations, there may be more than one method of treating a dental condition. This summary plan description includes an alternative benefits provision that may reduce benefits to the lowest-cost, generally effective, and necessary form of treatment.
- Certain conditions, such as age and frequency limitations, may impact your coverage. See the summary plan description for details.
- This plan includes continuation of coverage for employees with dental coverage from a previous employer. The member is required to complete the Continuity of Coverage form located on www.lfg.com. The form must be provided to us prior to the effective date to be eligible for continuation of coverage.

A complete list of benefit exclusions is included in the summary plan description.

This is not intended as a complete description of the coverage offered. Controlling provisions are provided in the summary plan description, and this summary does not modify coverage. A summary plan description will be made available to you that describes the benefits in greater detail. Refer to your summary plan description for your maximum benefit amounts.

Lincoln DentalConnect® health center Web content is provided by go2dental.com, Santa Clara, CA. Go2dental.com is not a Lincoln Financial Group® company. Coverage is subject to actual summary plan description language. Each independent company is solely responsible for its own obligations.

The Lincoln National Life Insurance Company (Fort Wayne, IN), does not conduct business in New York, nor is it licensed to do so. In New York, business is conducted by Lincoln Life & Annuity Company of New York (Syracuse NY). Both are Lincoln Financial Group Companies.

Lincoln Financial Group®

Dental Rate

Here's how little you pay with group rates.

As a New Century School employee, you can take advantage of this dental coverage for less than $0.38 a day. Plus, you can add loved ones to the plan for just a little more.

Your employer contributes 65% toward the cost of your coverage and 31% toward the cost of your dependents' coverage. Your estimated cost is itemized below.

Coverage	Monthly Rate
Employee only	$11.54
Employee & one family member	$34.28
Employee & two or more family members	$76.58

Vision Plan Summary

Metropolitan Life Insurance Company

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in network.
- Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco® Optical, Walmart, Sam's Club[3] and Visionworks.

In-network value added features:

Additional lens enhancements: In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements. [1]

Savings on glasses and sunglasses: Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.

Laser vision correction: [2]
Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

In-network benefits

There are no claims for you to file when you go to a participating vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

	Frequency
Eye exam	Once every 12 months
• Eye health exam, dilation, prescription and refraction for glasses: Covered in full after **$10** copay.	
• Retinal imaging: Up to a **$39** copay on routine retinal screening when performed by a private practice provider.	
Frame	Once every 12 months
• Allowance: **$150** after **$10** eyewear copay.	
• Costco, Walmart and Sam's Club: **$85** allowance after **$10** eyewear copay. You will receive an additional **20%** savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club.	
Standard corrective lenses	Once every 12 months
• Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after **$10** eyewear copay	
Standard lens enhancements[1]	Once every 12 months
• Polycarbonate (child up to age 18) and Ultraviolet (UV) coating: Covered in full after **$10** eyewear copay.	
• Progressive, Polycarbonate (adult), Photochromic, Anti-reflective, Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at metlife.com/mybenefits.	
Contact lenses instead of eye glasses	Once every 12 months
• Contact fitting and evaluation: Covered in full with a maximum copay of **$60**.	
• Elective lenses: **$150**	
• Necessary lenses: Covered in full after eyewear copay.	

We're here to help

Find a participating vision specialist:

www.metlife.com/mybenefits or call [1-855-MET-EYE1 (1-855-638-3931)]

Get a claim form:
www.metlife.com/mybenefits

General questions:
www.metlife.com/mybenefits or call [1-855-MET-EYE1 (1-855-638-3931)]

Out-of-network reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **In-network benefits** apply. Once you enroll, visit www.metlife.com/mybenefits for detailed out-of-network benefits information.

• Eye exam: up to **$45**	• Single vision lenses: up to **$30**	• Lined trifocal lenses: up to **$65**
• Frames: up to **$70**	• Lined bifocal lenses: up to **$50**	• Progressive lenses: up to **$50**
• Contact lenses:	• Lenticular lenses: up to **$100**	
- Elective up to **$105**		
- Necessary up to **$210**		

Exclusions and Limitations of Benefits

This plan does not cover the following services, materials and treatments.

Services and Eyewear

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your Dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the Group Policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program, or coverage provided by a government as an employer or Medicare.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen, or damaged (within the 12 month benefit period from date of purchase.)
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing, and cleaning.

Treatments

- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye(s).

Medications

- Prescription and non-prescription medication

[1]All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco, Walmart and Sam's Club to confirm availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

[2] Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

[3] Vision benefits offered through Walmart and

Important: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

M150A-10/10
Benefits are underwritten by Metropolitan Life Insurance Company, New York, NY.
Certain claims and network administration services are provided through Vision Service Plan. Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

Sam's Club are available beginning 08/01/2019 for participants in all states except Arkansas. Vision benefits offered through Walmart and Sam's Club will be available to participants in Arkansas beginning 01/01/2020.

Lincoln Financial Group®

New Century School

Benefits At-A-Glance

All Full-Time Employees

Life and AD&D Insurance

Safeguard the most important people in your life.

Consider what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like helping to cover everyday expenses, pay off debt, and protect savings. Accidental death and dismemberment (AD&D) insurance provides additional benefits if you die or suffer a covered loss in an accident, such as losing a limb or your eyesight.

At a glance:

- A cash benefit of $50,000 to your loved ones in the event of your death, plus an additional cash benefit if you die in an accident
- AD&D Plus: If you suffer an AD&D-covered loss in an accident, you may also receive benefits for the following in addition to your core AD&D benefits: coma, plegia, education, childcare, spouse training. Additional conditions are outlined in your policy.
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services.
- *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home.

Additional details

Continuation of coverage for ceasing active work: You may be able to continue your coverage if you leave your job for reasons including and not limited to Family and Medical Leave, lay-off, leave of absence, or leave of absence due to disability.

Waiver of premium: This provision relieves you from paying premiums during a period of disability that has lasted for a specified length of time.

Accelerated death benefit: Enables you to receive a portion of your policy death benefit while you are living. To qualify, a medical professional must diagnose you with a terminal illness with a life expectancy of fewer than 12 months.

Conversion: You may be able to convert your group term life coverage to an individual life insurance policy if your coverage decreases or you lose coverage due to leaving your job or for other reasons outlined in the plan contract.

Benefit reduction: Your employee Life/AD&D coverage amount will reduce by 35% when you reach age 65, by an additional 15% of the original amount when you reach age 70. Benefits end when you retire.

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

Monthly Life Insurance Premium
Calculate Your Premium.

Here's how little you pay with grouprates.

Your employer contributes 75% toward the cost of your coverage. Your estimated cost is itemized below.

Coverage	Monthly Rate
Employee Life and AD&D	$0.026

Calculation Example		Example
Step 1	Using the table above, enter the monthly rate	$0.026
Step 2	Enter the coverage amount in dollars.	$50,000
Step 3	Enter the desired coverage amount in increments of $1,000. *To calculate, divide the coverage amount by $1,000.*	50
Step 4	Calculate the monthly cost. *Multiply Step 1 by Step 3.*	$1.30

REMINDER: Please review your beneficiary(ies) to ensure they are up to date. It's good practice to review, and if necessary update, your beneficiary(ies) annually.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the policy, the policy will govern.

Group insurance products and services described herein are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. In New York, insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group® companies. Product availability and/or features may vary by state. Limitations and exclusions apply. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.

Lincoln Financial Group®

LCN-4231945-012522
GP-LADD-FLI001_Z01

Lincoln Financial Group®

All Full-Time Employees of New Century School

Benefits At-A-Glance

Voluntary Term Life and AD&D Insurance

The Lincoln Term Life and AD&D Insurance Plan:

- Provides a cash benefit to your loved ones in the event of your death
- Provides an additional cash benefit to your loved ones if you die — or to you if you lose a limb or your eyesight — in a covered accident when you add optional AD&D insurance
- Features group rates for New Century School employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services
- Also includes *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Employee	
Newly hired employee guaranteed coverage amount	$150,000
Continuing employee guaranteed coverage annual increase amount	Choice of $10,000 or $20,000
Maximum coverage amount	5 times your annual salary ($500,000 maximum in increments of $10,000)
Minimum coverage amount	$10,000
Optional AD&D coverage amount	Equal to the life insurance amount chosen
Spouse	
Newly hired employee guaranteed coverage amount	$50,000
Continuing employee guaranteed coverage annual increase amount	Choice of $5,000 or $10,000
Maximum coverage amount	50% of the employee coverage amount ($100,000 maximum in increments of $5,000)
Minimum coverage amount	$5,000
Optional AD&D coverage amount	Equal to the life insurance amount chosen
Dependent Children	
14 days to 6 months but less than 26 years (or 26 years if unmarried, & a full-time student) guaranteed coverage amount	$2,000, $4,000, $8,000, $10,000, $20,000
Age 1 day to 14 days guaranteed coverage amount	$2,000

What your benefits cover

Employee Coverage

Guaranteed Life and Optional AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to $150,000 without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase your coverage amount by $10,000 or $20,000 without providing evidence of insurability . If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to $20,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 5 times your annual salary ($500,000 maximum) with evidence of insurability. See the Evidence of Insurability page for details.
- The maximum coverage amount for employees 70 and older who are electing coverage for the first time is $50,000.
- Your coverage amount will reduce by 35% when you reach age 65 and an additional 15% of the original amount when you reach age 70.

Spouse Coverage - You can secure term life and AD&D insurance for your spouse if you select coverage for yourself.

Guaranteed Life and Optional AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to 50% of your coverage amount ($50,000 maximum) for your spouse without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase the coverage amount for your spouse by $5,000 or $10,000 without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to $10,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 50% of your coverage amount ($100,000 maximum) for your spouse with evidence of insurability.
- Coverage amounts are reduced by 35% when an employee reaches age 65 and an additional 15% when an employee reaches age 70.

Dependent Children Coverage - You can secure term life insurance for your dependent children when you choose coverage for yourself.

Guaranteed Life Insurance Coverage Options: $2,000, $4,000, $8,000, $10,000, and $20,000.

Additional Plan Benefits

Accelerated Death Benefit	Included
Premium Waiver	Included
Conversion	Included
Portability	Included
Seat Belt & Airbag	Included with AD&D
Common Carrier	Included with AD&D

Benefit Exclusions

Like any insurance, this term life and AD&D insurance policy does have exclusions.

For life insurance, a suicide exclusion may apply.

For AD&D, benefits will not be paid if death results from suicide, or death/dismemberment occurs while:

- Inflicting or attempting to inflict injury to one's self
- Participating in a riot or as a result of war or act of war
- Serving as a member of the military, including the Reserves and National Guard
- Committing or attempting to commit a felony
- Deliberately inhaling gas (such as carbon monoxide) or using drugs other than those prescribed by a physician and administered as prescribed
- Flying in a non-commercial airplane or aircraft, such as a balloon or glider
- Driving while intoxicated (with a blood alcohol level of .08 grams or more per 100 milliliters of blood)

In addition, the AD&D insurance policy does not cover sickness or disease, including the medical and surgical treatment of a disease.

A complete list of benefit exclusions is included in the policy. State variations apply.

Monthly Voluntary Life and AD&D Insurance Premium
Here's how little you pay with group rates.

Employee Age Range	Life Premium Rate Factor	Life & AD&D Premium Rate Factor
0 - 24	0.0000690	0.0000860
25 - 29	0.0000690	0.0000860
30 - 34	0.0000920	0.0001090
35 - 39	0.0001070	0.0001240
40 - 44	0.0001540	0.0001710
45 - 49	0.0002280	0.0002450
50 - 54	0.0003610	0.0003780
55 - 59	0.0005580	0.0005750
60 - 64	0.0007750	0.0007920
65 - 69	0.0014610	0.0014780
70 - 74	0.0023690	0.0023860
75 - 79	0.0023690	0.0023860
80 - 99	0.0023690	0.0023860

Group Rates for You

The estimated monthly premium for life insurance only or life and optional AD&D insurance is determined by multiplying the desired amount of coverage (in increments of $10,000) by the employee age-range premium factor.

$_____ X _____ = $_____
coverage amount premium factor monthly premium

Note: Rates are subject to change and can vary over time.

Employee Age Range	Life Only Premium Rate Factor	Life & AD&D Premium Rate Factor
0 - 24	0.0000690	0.0000860
25 - 29	0.0000690	0.0000860
30 - 34	0.0000920	0.0001090
35 - 39	0.0001070	0.0001240
40 - 44	0.0001540	0.0001710
45 - 49	0.0002280	0.0002450
50 - 54	0.0003610	0.0003780
55 - 59	0.0005580	0.0005750
60 - 64	0.0007750	0.0007920
65 - 69	0.0014610	0.0014780
70 - 74	0.0023690	0.0023860
75 - 79	0.0023690	0.0023860
80 - 99	0.0023690	0.0023860

Group Rates for Your Spouse

The estimated monthly premium for life insurance only or life and optional AD&D insurance is determined by multiplying the desired amount of coverage (in increments of $5,000) by the employee age-range premium factor.

$_____ X _____ = $_____
coverage amount premium factor monthly premium

Note: Rates are subject to change and can vary over time.

The Lincoln National Life Insurance Company

Please see prior page for product information.

Voluntary Life and AD&D Insurance At-A-Glance

Dependent Children Monthly Premium for Life Insurance Coverage

Coverage Amount	Monthly Premium
$2,000	$0.58
$4,000	$1.16
$8,000	$2.33
$10,000	$2.91
$20,000	$5.82

Group Rates for Your Dependent Children

One affordable monthly premium covers all of your eligible dependent children.

Note: You must be an active New Century School employee to select coverage for a spouse and/or dependent children. To be eligible for coverage, a spouse or dependent child cannot be confined to a health care facility or unable to perform the typical activities of a healthy person of the same age and gender.

New Century School provides this valuable benefit at no cost to you.

All Full-Time Employees

Short-term Disability Insurance

Protect your paycheck when you can't work.

Many medical conditions can keep you out of work. Short-term disability insurance helps you meet your financial obligations while you're recovering from an injury, illness, surgery, or childbirth.

AT A GLANCE:

- A cash benefit of 60% of your weekly salary (up to $1,250) when you are out of work for up to 13 weeks due to injury, illness, surgery, or recovery from childbirth
- A partial cash benefit if you can only do part of your job or work part time
- A prompt, responsive claims process

ADDITIONAL DETAILS

Sickness Elimination Period: You must be out of work for 7 days due to an illness before you can collect disability benefits. You can begin collecting benefits on day 8.

Accident Elimination Period: You must be out of work for 7 days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day 8.

First Day Hospitalization: The elimination period is reduced if you are hospitalized due to an illness or accidental injury. You can begin collecting benefits on the first day of hospitalization.

Benefits Integration: Your short-term disability benefits can coordinate with income from other sources, such as continued income or sick pay from your employer, during your disability. This allows you to receive up to 100% of your pre-disability income.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

New Century School provides this valuable benefit at no cost to you.

All Full-Time Employees

Long-term Disability Insurance

Keep getting a check when you're hurt or sick.

You always have bills to pay, even when you can't get to work due to injury, illness, or surgery. Long-term disability insurance helps you make ends meet during this difficult time.

AT A GLANCE:

- A cash benefit of 60% of your monthly salary (up to $5,000) starting 90 days after you are out of work and continuing up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is later
- *EmployeeConnect*SM services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance.
    - Program Services include:
    - Unlimited, 24/7 access to information and referrals
    - In-person help for short-term issues; up to five sessions with a counselor per person, per issue, per year.
    - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
    - Online tools, tutorials, videos and much more

ADDITIONAL DETAILS

Coverage Period for Your Occupation: 24 months. After this initial period, you may be eligible to continue receiving benefits if your disability prohibits you from performing any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits may be extended through the end of your maximum coverage period (benefit duration).

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

Lincoln Financial Group®

Delivering affordable eye care for you and your family

See the savings with the *Lincoln VisionConnect*® discount vision program

Spend less on your vision care, with *Lincoln VisionConnect*®, included in your dental insurance with Lincoln Financial Group.

Your vision discounts

Through the *Lincoln VisionConnect*® program, you'll receive:

- **Discounts** through a trusted network of eye doctors
- **$50** for an eye exam[1]
- **15% savings** on a contact lens exam[2]
- **Special pricing** on complete pairs of glasses and sunglasses
- **Reduced pricing** on laser vision correction through contracted facilities

[1] This cost is only available with the purchase of a complete pair of prescription glasses; otherwise, you'll receive 20% savings on an eye exam only.

[2] Applies only to contact lens exam, not materials. You are responsible for 100% of the contact lens material cost.

Lincoln VisionConnect® discount vision program

Lincoln Financial Group®

Name _____

Discount program only. Not an insurance program.

Save on vision care today

Visit disvis.lfg.com or call **800-877-7195** for more information.

Insurance products marketed by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations. LCN-3447273-021021 POD 4/21 **Z02 Order code: DTL-VIS-FLI001**

The *Lincoln VisionConnect*® discount vision program is provided by VSP Vision Savings Pass. The discount program is not a qualified health plan under the Affordable Care Act. The *Lincoln VisionConnect*® discount vision program is NOT insurance. The discount program provides discounts at certain healthcare providers for services. The range of discounts will vary depending on the type of provider and service. Plan members are obligated to pay for all healthcare services but will receive a discount from those healthcare providers who have agreed to provide discounts. The plan and its administrators have no liability for providing or guaranteeing service by providers or the quality of service rendered by providers. The VSP Vision Savings Pass does not take precedence over any other VSP coverage and cannot be combined with other VSP coverage. This plan is not available to members in Washington or to members with an employer located in Washington.

VSP and WellVision® Exam are registered trademarks of Vision Service Plan. Insurance products are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. In New York, insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group® companies. Product availability and/or features may vary by state. Limitations and exclusions apply.

 LincolnFinancial.com

Visit disvis.lfg.com or call 800-877-7195 for more information.

The resources you need to meet life's challenges

EmployeeConnect℠ offers professional, confidential services to help you and your loved ones improve your quality of life.

In-person guidance

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and **25% off** subsequent meetings

Unlimited 24/7 assistance

You and your family can access the following services any time — online, on the mobile app, or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more
- Legal information and referrals for family law, estate planning, and consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online resources

EmployeeConnect offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit **GuidanceResources.com** or download the **GuidanceNow**℠ mobile app. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets, and more

EmployeeConnect℠

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress

LTD-EAPEE-FLI001_Z03

We partner with your employer to offer this service at no additional cost to you!

EmployeeConnect counselors are experienced and credentialed.

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice, and referrals. All counselors hold master's degrees, with broad-based clinical skills, and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized information for each work-life service you use.

Take advantage of *EmployeeConnect*

For more information about the program, visit **GuidanceResources.com**, download the **GuidanceNow** mobile app, or call **888-628-4824**.

GuidanceResources.com login credentials:
Username: LFGSupport Password: LFGSupport1

LincolnFinancial.com

LCN-2836182-112019
MAP 9/21 **Z03**
Order code: LTD-EAPEE-FLI001

Lincoln Financial Group®

*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

To find out more:

- Visit GuidanceResources.com
  username: LFGSupport password: LFGSupport1
- Download the GuidanceNow℠ mobile app
- Call 888-628-4824

Lincoln Financial Group® | ComPsych® GuidanceResources® Worldwide

Lincoln Financial Group®

LOGO

Lincoln VisionConnect® and EPIC Hearing Service Plan

Enjoy discounted rates on vision and hearing care

As the cost of health care rises, so does the cost of vision and hearing care. But did you know that your dental insurance also includes discounts on glasses, hearing aids, and more? The *Lincoln VisionConnect* program and EPIC Hearing Service Plan can help you save on the vision and hearing services and products you need.

See the savings

The *Lincoln VisionConnect* discount vision program provides savings on eye care, eyewear, WellVision® exams, retinal screenings, lens enhancements, and laser vision correction. Through the program, you'll receive:

- **Discounts** through a trusted network of eye doctors
- **One rate of $50** for an eye exam[1]
- **15% savings** on a contact lens exam[2]
- **Special pricing** on complete pairs of eyeglasses and sunglasses
- **Reduced pricing** on laser vision correction through contracted providers

Hear the difference

Lincoln's EPIC Hearing Service Plan provides access to a network of more than 7,000 credentialed professionals who provide comprehensive services and products — including the most advanced hearing aid technology. And thanks to specially negotiated rates, you pay less for routine hearing tests and hearing aids and can receive:

- **50% to 80% off standard industry prices** on 2,000+ top brand hearing aids
- **Free charging case or one-year supply of batteries** with hearing aid purchase
- **No-cost hearing test** with your hearing aid evaluation
- **Three-year warranty** on all hearing aids covers repair, damage, and one-time loss
- **Virtual care with hearing aids** delivered directly to your door or in-person care through the largest hearing care provider network in the country

[1] This cost is only available with the purchase of a complete pair of prescription glasses. Otherwise, you'll receive 20% savings on an eye exam only.
[2] Applies only to contact lens exam, not materials. You're responsible for 100% of the contact lens material cost.

Lincoln VisionConnect discount vision program

Lincoln Financial Group®

Name _____

Discount program only. Not an insurance program.

Save today

Visit disvis.LFG.com or call **800-877-7195** for more information about your **vision benefits**.

Visit epichearing.com or call **888-899-1459** to learn more about your **hearing benefits**.

Insurance products marketed by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York

Visit disvis.LFG.com or call 800-877-7195 for more information.

Because life doesn't always go as planned.

No matter how well you plan, unexpected challenges arise. When they do, help and support are nearby—thanks to *LifeKeys*® services from Lincoln Financial Group.

LifeKeys services include:

Discounts on shopping and entertainment

GuidanceResources® includes 24/7 online access to the Working Advantage discount network. You can save up to 60% on a variety of products and services, including electronics, health and fitness, Broadway shows, and much more. Discounts are also available in the GuidanceNow mobile app, available in the Apple App Store and on Google Play.

Help with important life matters

You'll find support tools and advice on a wide range of topics, including legal, financial, family, and career, on GuidanceResources online. Stay in the know on matters that impact your personal and professional life.

Protection against identity theft

Identity theft is widespread, and everyone is vulnerable. *LifeKeys* includes an online resource for information that can help you recognize and prevent identity theft — and restore your good name should your identity be compromised.

Online will preparation

Creating a will allows you to make vital decisions ahead of time, including naming a guardian for your children or designating who will receive your property and assets after you pass away. Without a will, state officials will distribute your estate. *EstateGuidance*® offers a secure, efficient way to create and execute a will so you can rest easy knowing you've planned ahead for your family.

Guidance and support for your beneficiaries

LifeKeys is a comprehensive program that offers resources to help your loved ones address a range of common concerns should they experience a loss. Services include grief counseling, financial and legal advice, and support when coping with the challenges of day-to-day life. Services are detailed on page 2.

Your life and accidental death and dismemberment (AD&D) insurance policies include access to a wide range of services to help you and your loved ones navigate life's most important matters.

Help, guidance, and support for beneficiaries following a loss

The emotional impact of losing a loved one can be deep and long-lasting. All too often, financial or legal issues can add to the stress. *LifeKeys* services can be a welcome resource for your beneficiaries.

Your beneficiaries will have access to six in-person sessions for grief counseling, legal or financial information, and unlimited phone counseling. Services are available for up to one year after a loss.

Grief counseling — advice, information, and referrals on:

- Coping with loss
- Stress, anxiety, and depression
- Memorial planning information
- Concerns about family, including children and teens

Legal support — access to legal information on:

- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents for beneficiaries

Financial services — online resources and advice from financial specialists on:

- Estate planning
- Budgeting
- Overcoming debt
- Bankruptcy
- Investments

Help with everyday life — comprehensive information on:

- Finding child care or elder care
- Financing a home
- Moving and relocation
- Making major purchases

Access *LifeKeys* services. Visit GuidanceResources.com, download the GuidanceNow mobile app, or call 855-891-3684. First-time users: enter web ID: LifeKeys.

LincolnFinancial.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-3985132-121521
MAP 1/22 **Z04**
Order code: LFE-LKEYE-FLI001

Lincoln Financial Group®

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. ComPsych® is not a Lincoln Financial Group® company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations. GuidanceResources® is a trademark of ComPsych® Corporation.

State limitations apply. Beneficiary grief counseling is the only benefit available to a beneficiary(ies) of policies issued in the state of New York. Online will prep is the only benefit available to insured employee and dependents of policies issued in the state of Washington.

Lincoln FuneralPrep: Help when you need it most

With many details to manage and decisions to make, the funeral planning process can be overwhelming. To help you every step of the way, we've partnered with **FuneralDecisions.com** to provide Lincoln FuneralPrep, a comprehensive planning service.

What is Lincoln FuneralPrep?

An online portal that provides a breadth of resources, Lincoln FuneralPrep can help with at-need planning or pre-planning — 24 hours a day.

At-need planning

When grieving the loss of a loved one, you're dealing with far more than a life insurance claim. Lincoln FuneralPrep helps you reduce the stress and uncertainty of making urgent decisions during an emotional time.

Pre-planning

Being prepared is one of the best things you can do for your family. In addition to providing pre-planning resources, Lincoln FuneralPrep can direct you to funeral professionals who can provide expert guidance and advice.

How to access Lincoln FuneralPrep

You can access Lincoln FuneralPrep in two ways.

1 Visit the self-service online portal: LincolnFuneralPrep.com/GPLife.

The online portal at LincolnFuneralPrep.com/GPLife includes a wealth of online funeral planning resources and services, including the ability to:

Search for funeral homes

Access an interactive list of funeral homes and cemeteries around the country. You can filter by location, service, and budget.

Access market information

Review price ranges and service options in your selected geographic location.

View guides and checklists

Organize your priorities, consider your options, and make informed decisions based on your preferences with our handy online guides and checklists.

2 Connect with a funeral planning consultant

Work with a funeral planning expert who can guide you through the pre-planning process and:

Help compare options

Get help comparing pre-planning options, even if you don't have a specific funeral home in mind.

Provide personalized service

Work with our experts to ensure your plans reflect your wishes and meet your objectives.

Offer objective guidance

Get guidance on planning options and various funding strategies.

LincolnFinancial.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-3795167-092721
ADA 1/23 **Z08**
Order code: LFE-FNPRP-FLI001

During difficult times, we're here for you and your loved ones.

To learn more, visit LincolnFuneralPrep.com/GPlife.

Lincoln Financial Group®

Group insurance products and services described herein are issued by The Lincoln National Life Insurance Company.

Not available in New York.

Caring support and assistance when you travel

Lincoln *TravelConnect*® services offer security and reassurance – helping make travel less stressful. If you're enrolled in life and/or accidental death and dismemberment insurance, you and your loved ones can count on *TravelConnect*® services 24 hours a day, 7 days a week.

Services you can count on during an emergency

You'll have dedicated support if you face an emergency when you're 100 or more miles from home. *TravelConnect*® helps with:

- Arranging travel if you're injured and need emergency evacuation to a medical facility
- Managing travel for a companion and/or your dependent children, including transportation expenses and accommodations of a qualified escort
- Planning and paying for a safe evacuation because of a natural disaster or a political or security threat
- Arranging transportation of a deceased traveler
- Securing emergency pet boarding and/or return and vehicle return

Ongoing support when you're far from home

From planning the trip until you're home, these *TravelConnect*® services can help you on your way.

- Medical record requests
- Medication and vaccine delivery
- Medical, dental, and pharmacy referrals
- Corrective lenses and medical device replacement
- Legal consultation
- Recovering lost or stolen documents or luggage
- ID recovery assistance
- Language translation services
- Destination information

TravelConnect®

Lincoln Financial Group®

GLOBAL ASSISTANCE PROGRAM

Provided by On Call International
Medical, security, and travel assistance services for participants traveling 100+ miles from home

Visit MyOnCallPortal.com and enter Group ID: **LFGTravel123** for access to plan documents, international calling instructions, and destination information.

For a complete list of *TravelConnect*® services, go to **MyOnCallPortal.com** and enter Group ID **LFGTravel123.**

TravelConnect® services are provided by On Call International, Salem, NH. On Call International is not a Lincoln Financial Group® company and Lincoln Financial Group does not administer these services. Each independent company is solely responsible for its own obligations. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. Coverage is subject to contract language that contains specific terms, conditions, and limitations, which can be found in the program description.

The *TravelConnect*® program is not available to insured employees and dependents of policies issued in the states of New York and Washington. Access Only program available to insured employees and dependents of policies issued in the state of Missouri and Texas. Benefits provided under the Access Only program exclude payment for paid services.

Not available in New York and Washington.

LincolnFinancial.com

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LCN-3885715-102621
MAP 12/21 **Z03**
Order code: LFE-TRVFE-FLI001

Lincoln Financial Group®

If you need medical, security, or travel assistance, regardless of the nature or severity of your situation, contact On Call International 24 hours a day:

Call collect from anywhere in the world:
603-328-1955
Call toll free from U.S. or Canada:
866-525-1955
Email: mail@OnCallInternational.com

Global assistance services must be coordinated and approved by On Call in order to be covered.

See your plan description for full terms and conditions of the services offered in your plan.

On Call International
A member of the **Tokio Marine HCC** group of companies

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MetLaw provides you with telephone and office consultations for an unlimited number of matters with the attorney of your choice. During the consultation, the attorney will review the law, discuss your rights and responsibilities, explore your options and recommend a course of action.

Legal Representation

Estate Planning

- Simple Wills
- Complex Wills
- Revocable Trusts
- Irrevocable Trusts
- Powers of Attorney (healthcare, financial, childcare)
- Healthcare Proxies
- Living Wills
- Codicils

Money Matters

- Personal Bankruptcy/Wage Earner Plan
- Debt Collection Defense
- Foreclosure Defense
- Repossession Defense
- Garnishment Defense
- Identity Theft Defense
- Tax Collection Defense
- Negotiations with Creditors
- Tax Audit Representation (Municipal, State, Federal)

Real Estate Matters

- Sale, Purchase or Refinancing of primary, second or vacation home
- Home Equity Loans for primary, second or vacation home
- Eviction & Tenant Problems (for tenant)
- Security Deposit Assistance (for tenant)
- Boundary or Title Disputes
- Property Tax Assessments
- Zoning Applications

Elder Law Matters

Consultation & Document Review for issues related to your parents:

- Medicare
- Medicaid
- Prescription Plans
- Nursing Home Agreements
- Leases
- Notes
- Deeds
- Wills
- Powers of Attorney

Family Law

- Adoption & Legitimization
- Guardianship
- Conservatorship
- Name Change
- Prenuptial Agreement
- Protection from Domestic Violence

Traffic Offenses*

- Defense of Traffic Tickets (excludes DUI)
- Driving Privileges Restoration (includes License Suspension due to DUI)

Document Preparation

- Affidavits
- Deeds
- Demand Letters
- Mortgages
- Promissory Notes
- Review of Any Personal Legal Document

Immigration Assistance

- Advice & Consultation
- Review of Immigration Documents
- Preparation of Affidavits
- Preparation of Powers of Attorney

Juvenile Matters

- Juvenile Court Defense (includes Criminal Matters)
- Parental Responsibility Matters

Consumer Protection

- Disputes over Consumer Goods & Services
- Small Claims Assistance

Defense of Civil Lawsuits

- Civil Litigation Defense
- Incompetency Defense
- Administrative Hearings
- School Hearings
- Pet Liabilities

Personal Property Protection

- Consultation & Document Review for personal property issues
- Assistance for disputes over goods & services

For More Information:

Visit **info.legalplans.com** and enter access code GETLAW or call our Client Service Center at 800-821-6400 (Monday – Friday, 8 am to 7 pm EST/EDT).

$19.50 per month

covers employee, spouse and dependents

The cost is automatically deducted from your paycheck.

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Network attorneys provide representation for personal injury, probate & estate administration matters at reduced fees.

Family Matters™**

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E-Services

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Available on the App Store

Google play

SPECIAL NOTICES

PLAN YEAR: 2024

KRAUS-ANDERSON® *Insurance*

CONTACT INFORMATION

PLAN ADMINISTRATOR	
Contact Name:	Deema Sorri
Phone Number:	651-478-4535
E-mail:	business@newcenturyschool.net
HEALTH INSURANCE PROVIDER	
Health Insurer:	Medica
Customer Service:	800-575-2330
Website:	www.medica.com
PRIVACY OFFICER	
Contact Name:	Ahmed Ali
Business Address:	1380 Energy Lane, Suite 108
	St. Paul, MN 55108
Phone Number:	651-478-4535
E-mail:	ahmed.ali@newcenturyschool.net
Website:	www.newcenturyschool.net
MEDICARE PART D	
Creditable:	$1,000-$40-25% Copay
Creditable:	$2,500-100% HSA

The information in this Special Notices is presented is based on information required by law. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Special Notices and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact your plan administrator.

WHCRA ENROLLMENT NOTICE

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 manager 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 complication of mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: see your Certificate of Coverage or Summary Plan Description. If you would like more information on WHCRA benefits, call Customer Service at the number on the back of your ID card.

SPECIAL ENROLLMENT NOTICE

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

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

To request special enrollment or obtain more information contact your plan administrator.

NEWBORN'S ACT DISCLOSURE

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, required 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).

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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 8.39% 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.

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.

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.

YOUR INFORMATION, YOUR RIGHTS, OUR RESPONSIBILITIES

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

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 your health and claims record	• You can ask to see or get a copy of your health and claims records and otherhealth 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 correct or incomplete. Ask us how to do this. • We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communication	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say “no” if it would affect your care.
Get a list of these with whom we’ve shared information	• You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copypromptly.
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 Privacy Officer contact information. • 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 other involved in payment for your care • Share information in a disaster relief situations • Contact you for fundraising efforts • 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 us or share your health information? We typically use or share your health information in the following ways.

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

How else can we use or share your health information? We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: 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 suchas: • 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 orsafety
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 procurementorganizations. • We can share health information with a coroner, medical examiner, orfuneral 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 healthinformation.
- 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 ofit.
- 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 yourmind.

For more information see: www.hhs.gov/oct/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 website, and we will mail a copy to you.

GINA DISCLOSURE

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

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

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

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

MENTAL HEALTH & ADDICTION EQUITY ACT DISCLOSURE

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the company's group health plan with respect to mental health or substance use disorder benefits, pleasecontact the plan administrator.

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
The end of employment or reduction of hours of employment; Death of the employee; or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

ADA WELLNESS PROGRAM NOTICE

Our wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the plan administrator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and our company may use aggregate information it collects to design a program based on identified health risks in the workplace, we will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is your doctor in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the plan administrator.

Wellness Program Disclosure

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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. 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://kynect.ky.gov 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 and CHIP**
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 January 31, 2024, 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)

Your Rights and Protections Against Surprise Medical Bills

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

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

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

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

You're protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia,

pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

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

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

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

- The US Department of Health and Human Services at:

  Phone: 800-985-3059

  Website: https://www.cms.gov/nosurprises/consumers

- Your state agency, which can be found at:

  https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE CREDITABLE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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. We have determined that the prescription drug coverage offered by the company 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 drugplan.

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 coverage will not be affected. Please see the Insurance Carrier for additional information regarding plan coverage

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

When will you pay a higher premium (penalty) to join a Medicare drug plan?

- You should also know that if you drop or lose your current coverage 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 as the plan administrator 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 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).

GLOSSARY

Glossary is for benefit general terms and may not all apply to your plan(s).

Allowed Amount - The highest amount that will cover (pay) a service.

Benefit Period - When services are covered under your plan. It also defines the time when benefit maximums, deductibles and coinsurance limits build up. It has a start and end date. It is often one calendar year for health insurance plans. *Example: You may have a plan with a benefit period of January 1 through December 31 that covers 10 physical therapy visits. The 11th or more sessions will not be covered.*

Brand - A prescription drug product which is manufactured and marketed under a trademark or name by a specific drug manufacturer, or that is identified as a brand name product.

Coinsurance - A certain percentage you must pay each benefit period after you have paid your deductible. This payment is for covered services only. You may still have to pay a copay. *Example: Your plan might cover 80 percent of your medical bill. You will have to pay the other 20 percent. The 20 percent is the coinsurance.*

Coinsurance Limit (or Maximum) - The most you will pay in coinsurance costs during a benefit period.

Condition - An injury, ailment, disease, illness, or disorder.

Contract - The agreement between an insurance company and the policyholder.

Coordination of Benefits (COB) – A process to determine who pays first when two or more health insurance plans are responsible for paying the same medical claim. You may be required to complete a form from the insurer(s) to help with this determination. Claims are typically held until COB is established.

Copayment (Copay) - The amount you pay to a healthcare provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

Covered Charges - Charges for covered services that your health plan paid for. There may be a limit on covered charges if you receive services from providers outside your plan's network of providers.

Covered Person - Any person covered under the plan.

Covered Service - A healthcare provider's service or medical supplies covered by your health plan. Benefits will be given for these services based on your plan.

Creditable Coverage - Coverage of a person under any of these:
A group health plan. This includes church and governmental plans.
Health insurance coverage.
Medicare (Part A or Part B of Title XVIII of the Social Security Act).
Medicaid (Title XIX of the Social Security Act, other than coverage consisting only of benefits under Section 1928).
The health plan for active military personnel. This includes TRICARE.
The Indian Health Service or other tribal organization program.
A state health benefits risk pool.
The Federal Employees Health Benefits Program.
A public health plan (as defined in federal regulations).
A health benefit plan under section 5 (c) of the Peace Corps Act.
Any other plan which gives complete hospital, medical and surgical services.

Deductible - The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time). *Example: If your plan has a $2,000 annual deductible, you will be expected to pay the first $2,000 toward your healthcare services. After you reach $2,000, your health insurer will cover the rest of the costs.*
Dependent Coverage - Coverage for your dependents who qualify.

Emergency Medical Condition - A medical problem with sudden and severe symptoms that must be treated quickly. In an emergency, a person with no medical training and an average knowledge of health/medicine could reasonably expect the problem could:
Put a person's health at serious risk.
Put an unborn child's health at serious risk.
Result in serious damage to the person's body and how his or her body works.
Result in serious damage to a person's organ or any part of the person.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure - These are not approved by the U.S. Food and Drug Administration (FDA) or are not considered the standard of care

Explanation of benefits - the health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.

Generic - A prescription drug product that is chemically equivalent to a brand-name drug; or that the claims administrator identifies as a generic product based on available data resources.

Health Assessment - A health survey that measures your current health, health risks and quality of life.

Inpatient Services - Services received when admitted to a hospital and a room and board charge is made.

Institution (Institutional) - A hospital or certain other facility.

Legal Guardian - The person who takes care of a child and makes healthcare decisions for the child. This person is the natural parent or was made caretaker by a court of law.

Medical Care - Medical services received from a healthcare provider or facility to treat a condition.

Medically Necessary (or Medical Necessity) - Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:
Accepted as standard practice. It can't be experimental or investigational.
Not just for your convenience or the convenience of a provider.
The right amount or level of service that can be given to you.
Example: Inpatient care is medically necessary if your condition can't be treated properly as an outpatient service.

Medicare - A federal program for people aged 65 or older that pays for certain healthcare expenses.

Network Provider/In-network Provider - A healthcare provider who is part of a plan’s network.

Non-covered Charges - Charges for services and supplies that are **not** covered under the health plan. Examples of non-covered charges may include things like acupuncture, weight loss surgery or marriage counseling. Consult your plan for more information.

Non-network Provider/Out-of-network Provider - A healthcare provider who is **not** part of a plan’s network. Costs associated with out-of-network providers may be higher or not covered by your plan. Consult your plan for more information.

Outpatient Services - Services that do not need an overnight stay in a hospital. These services are often provided in a doctor's office, hospital, or clinic.

Out-of-pocket Cost - Cost you must pay. Out-of-pocket costs vary by plan and each plan has a maximum out-of-pocket (MOOP) cost. Consult your plan for more information.

Per Member Per Month (PMPM) - The average cost or quantity per month based on active membership.

Pre-existing condition - a health problem that has been diagnosed, or for which you have been treated, before buying a health insurance plan.

Preventive Care - Regular care that is generally performed by a primary care physician (e.g., physicals, health screenings).

Primary Care Provider - A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services.

Provider (Healthcare Provider) - A hospital, facility, physician, or other licensed healthcare professional.

Urgent Care Provider - A provider of services for health problems that need medical help right away but are not emergency medical conditions.

Specialist - A physician that specializes in a specific area of medicine.

Waiting period - the period of time that an employer makes a new employee wait before he or she becomes eligible for coverage under the company's health plan. Also, the period of time beginning with a policy's effective date during which a health plan may not pay benefits for certain pre-existing conditions.