BENEFITS MANUAL

January 1, 2021

NOVA CLASSICAL ACADEMY

QUESTIONS

Kriscel Estrella at 651-209-6320 ext. 306 or kestrella@novaclassical.org

In this issue

What's new?

Elections you make during open enrollment will become effective January 1, 2021.

This brochure includes the benefits and enrollment material offered at Nova Classical Academy for 2021. We encourage you to take the time to read through and explore your benefits options. At Nova Classical Academy, we value our employees and are committed to providing a comprehensive and competitive benefits package.

Certain benefits you elect require an employee contribution. In some cases, those contributions will be deducted from your check on a pre-tax basis; in other cases the deduction will be made after-tax to avoid certain tax consequences to you and the company. For taxability of benefit elections, please contact Kriscel Estrella at **651-209-6320 ext. 306** or **kestrella@novaclassical.org**.

Required notices are located at the end of this packet and include:

- HIPAA Portability Notice
- HIPAA Notice of Privacy Practices
- Notice of Healthcare Exchange
- CHIP Notice
- WHCRA Notice

HEALTH PLAN SUMMARY

Effective January 1, 2021, we are changing our health plan carrier to PreferredOne for all benefit-eligible employees.

About the Health Plan: Preventive care is covered at 100% and no deductible applies. For other services, these plans require a deductible before eligible services are paid at 100%.

In-Network	$500 Plan	$2000 HSA Plan
Deductible *per calendaryear*	$500/single $1,500/family	$2,000/single $4,000/family
Out of Pocket Max *per calendaryear*	$3,000/single $6,000/family	$2,000/single $4,000/family
Physician Services *Office visits, Urgent Care Clinic, Retail Health Clinics, Chiropractic Manipulation*	You pay $25 per visit	You pay $0 per visit after deductible
Preventive Services *Well child, Immunizations, Certain Prenatal Services, Screening*	You pay $0	You pay $0
Mental/ Behavioral/ Substance Use *Outpatient*	You pay $25 per visit	You pay $0 per visit after deductible
Ambulance	You pay 25% after deductible	You pay 0% after deductible
Hospital	You pay 25% after deductible	You pay 0% after deductible
Prescription Drugs *Retail (31-day supply)* Generic Preferred Brand Non-Preferred Brand	 You pay $10 or $25 You pay $50 You pay 25% after deductible	 You pay 0% after deductible
Specialty Drugs	You pay 25% after deductible	You pay 0% after deductible
90 dayRx / Mail Order Generic Preferred Brand Non-Preferred Brand	 You pay $25 or $60 You pay $125 Non-Preferred Brand Not Covered	 You pay 0% after deductible Non-preferred Brand not covered

Please review your benefit plan summary document for more detailed coverage information.

PreferredOne®

Always use a network provider for highest benefit levels from your plan. Our health plans use the Connect and Horizon networks.

BALANCE BILLING

The amount that the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. Always use an in-network provider for the highest coverage of services.

SUMMARY OF BENEFITS COVERAGE

Refer to your summary of benefit coverage (SBC) for a more detailed explanation about your health plan benefits, including mail order prescriptions and other health services.

QUESTIONS?

Call customer service at **763-847-4477**, **800-997-1750** or call the phone number on the back of your ID card or visit **www.preferredone.com**.

HEALTH SAVINGS ACCOUNT ADVANTAGES

Is a health savings account right for me?

Like any health care option, an HSA has advantages and disadvantages. As you weigh your options, think about your budget and what health care you are likely to need in the next year.

If you are generally healthy and want to save for future health care expenses, an HSA may be an attractive choice.

Or if you are near retirement, an HSA may make sense because the money in the HSA can be used to offset costs of medical care after retirement.

On the other hand, if you think you might need expensive medical care in the next year and would find it hard to meet a high deductible, an HSA might not be your best option.

Contributions cannot be made to the HSA of members who are entitled to (eligible and enrolled in) benefits under Medicare, or other disqualifying coverage.

If you are covered on the High Deductible Health Plan (HDHP), but you are also covered on another group health plan (such as your spouse's group plan) that is not an HDHP, you would also be ineligible to make contributions to an HSA.

Also an HSA is not available to employees who are eligible for a spouse's medical flexible spending arrangement (FSA), unless the spouse's medical FSA is a limited medical FSA.

Please notify HR if you become enrolled in Medicare or other disqualifying coverage so that HSA contributions can be terminated and avoid adverse tax consequences for you. If you are eligible for, but not enrolled in, Medicare please contact HR before deciding to continue any HSA contributions.

How much can you put in the health savings accounts?

Maximum contributions are $3,600 for single coverage and $7,200 for family coverage for 2021, total household combined.

Your Health Savings Account will be offered through Further. To enroll, you must fill out the applicable forms during your benefits enrollment in K-Pay.

TOP REASONS TO HAVE AN HSA

Tax Saving & Earned Interest — Contributions are tax-deductible and earn tax-free interest.

Portability — You own your account, so even if you change jobs, your HSA funds are yours to keep.

Affordable Health Coverage — Use the HSA to cover 100% of out-of-pocket costs for routine medical expenses, such as office visits, lab tests, and prescription medications.

Reduced Insurance Premiums — The cost of coverage under a qualified HDHP is typically lower than the other plan.

Long-Term Savings — Contributions to your HSA accumulate and roll over year-to-year with no limit, which allows the account to grow tax-deferred.

Retirement Bonus — After age 65, funds may be withdrawn for any reason with no penalties. (If used for non-medical purposes, however, taxes will be imposed).

Safety Net — AN HSA has no "use it or lose it" restrictions, so balances can be built up to use for major medical events.

Coverage for the "Extras" — HSA funds may be used to pay for services often not covered by a medical plan, including dental and vision expenses.

Money That Works for You — Balances over a certain amount may be invested.

Empowerment — Take control of your health care decisions, including which providers you want to use, to ensure your health care dollars are spent wisely.

How do I use the HSA to pay for medical care?

It is rather simple. Here are the steps:

1. You and/or the company puts money into the HSA.
2. You or a dependent receives medical services.
3. A bill for medical services is submitted as a claim to PreferredOne.
4. You receive an Explanation of Benefits for the service, which will reflect the amount due to the provider.
5. At this time you can choose to:
   - Use your HSA funds to pay the provider directly for the amount due
   - Pay the provider with personal funds and request reimbursement
   - Use your funds and save your HSA dollars for future medical expenses
6. Process repeats until deductible and out-of-pocket maximums are met, after which benefits are paid for the remaining plan year.

How do I find information about medical costs and quality so I can make informed choices?

Call Member Services or log on to **www.preferredone.com** to search for providers and clinics that offer the medical services you need at the best cost.

Can I withdraw money from an HSA for nonmedical expenses?

Yes, but if you withdraw funds for nonmedical expenses before you turn 65, you have to pay taxes on the money and a 20% penalty. If you take money out after you turn 65, you pay normal income taxes but no penalties.

BE A SMART HEALTHCARE CONSUMER!

You have different care options to choose. Gaining a better understanding of your options now can help you save both time and money when you need to seek care. Options for treatment include:

Convenience Care, Online Care: Located inside of retail stores or online, visit these for common aliments like strep throat, pink eye, bladder infection, etc. **Cost: $**

Doctor's Office: Staffed by doctor, PA and nurses, visit this for care of illnesses, injuries, preventive care, etc.
Cost: $$

Urgent Care Clinic: Staffed by doctor, PA and nurses, visit this for care of minor illnesses or injuries that require **immediate** attention.
Cost: $$$

Emergency Room: Located inside of a hospital, visit this for serious illnesses, injuries or life-threatening issues, such as, chest pains, shortness of breath, burns, head injuries, etc.
Cost: $$$$

HEALTH PLAN PREMIUMS

The company will continue to pay a portion of your premiums. Premiums are shown per month effective January 1, 2021:

OA300/Horizon

	$500.75.25	$2000.100 HSA
Employee	$158.43	$94.61
Employee + spouse	$1,000.12	$853.31
Employee + children	$805.89	$678.23
Family	$1,679.93	$1,466.11

PreferredHealth/Connect

	$500.75.25	$2000.100 HSA
Employee	$124.36	$63.90
Employee + spouse	$921.74	$782.67
Employee + children	$737.74	$616.79
Family	$1,565.77	$1,363.21

HEALTH SAVINGS ACCOUNT

- Contributions are tax deductible and interest earnings are tax-free.
- Your HSA contributions accumulate and roll over each year.
- Account funds remain until spent. There is no use it or lose it rule.
- Account funds should only be used for qualified expenses.
- Non-qualified expenses are subject to a 20% penalty and charged as taxable income.
- Withdrawals are tax-free when used for eligible expenses.
- Maximum contributions are $3,600/single or $7,200/family for 2021, total household combined.
- If you fund a new HSA with the max contributions, you will need to be enrolled in the HSA for the entire plan year, or penalties apply.
- Catch-up contributions may be made annually for those 55 and older, up to $1,000.
- HSA accounts are not available to employees who are eligible for a spouse's medical flexible spending arrangement (FSA), unless the spouse's medical FSA is a limited medical FSA.
- Contributions cannot be made to the HSA of members who are entitled to (eligible and enrolled in) benefits under Medicare, or other disqualifying coverage. Please notify HR if you enroll in Medicare or other disqualifying coverage to terminate HSA contributions and avoid adverse tax consequences. If you are eligible for (but not enrolled in) Medicare please contact HR before continuing any HSA contributions.
- Your HSA administrator: **Further**.

VALUE – ADDED SERVICES

Resources for your total health support from **PreferredOne**:

Register for My Account: Access your health insurance information by setting up a personalized PreferredOne My Account. View your secure personal account/claims, order ID cards, find a provider, register to receive electronic EOBs, find information on the general costs of medical conditions at individual clinics and hospitals, review pharmacy information, discover member discount programs and more. Visit **www.preferredone.com** and access My Account for additional information on all of the resources outlined on this flyer.

Health Risk Assessment: Members may take this free online assessment, designed to give you an evaluation of your current health status. The assessment is a self-scored appraisal with immediate feedback via a private/secure web link and creates a baseline from which you can make lifestyle modifications.

Healthy Mom and Baby: Expectant parents receive a free maternity management program with support and information to help promote a healthy pregnancy. Once enrolled, a PreferredOne nurse will contact you to discuss your pregnancy, focusing on those areas that are potentially high risk. You will also receive pregnancy manuals and a gift card when you complete the program. Call **800-940-5049, enter #1 and ext. 3456.**

Chronic and Rare Conditions Care: Our one-to-one nurse care coordination and health coaches help members gain the knowledge and skills to successfully manage chronic health conditions. Call **800-940-5049, enter #1 and ext. 3456**.

Tobacco Cessation: The *Quit for Life*® plan is available for those who would like to quit using tobacco products. The program is a telephonic based self-referral program that provides an easy to use printed workbook to help you stick to your quitting plan. *Quit for Life*® will also help you decide which type, dose and duration of nicotine substitution or medication is right for you and teach you proper use (Nicotine replacement products are not covered through this program. Check your plan pharmacy benefits for coverage of these products). It is free and confidential. Quit today, for life. Call the *Quit for Life*® program at **866-784-8454**.

SAVE MONEY, STAY HEALTHY

Healthy Member Discounts: Save on a variety of products and services. Discounts are at Curves, 2nd Wind Exercise, Healthy Simple Life, Jazzercise, Seattle Sutton's Healthy Eating, QualSight Lasik, and Amplifon Hearing Health Care.

Vital Worklife Employee Assistance Program (EAP): Get 24-hour free and confidential telephone consultation and professional support for financial issues, marital problems and more. Contact Vital Worklife at **800-383-1908**.

Medical Cost Tools: Compare costs for common services from a variety of primary care and medical specialty clinics or different PreferredOne network providers. You can also check out average costs for facility and medical imaging procedures.

Healthwise® Knowledgebase: A variety of comprehensive health and wellness information on over 7,500 topics. Browse the many interactive tools, health topics and learning centers, including health topics by category, support groups, symptom checker and more.

BENEFITS MANUAL 2021

Nova Classical Academy

Nice Healthcare

Administered by Nice Healthcare

Nova Classical Academy is delighted to offer our employees Nice Healthcare. Nice Healthcare offers chat, video and in-home direct primary care visits. They also provide in-home labs (blood work), X-Rays, chronic condition management, virtual physical therapy, and much more, all at no cost to you.

Nice Healthcare is available to you if you are enrolled in any of Nova Classical Academy's health plans. Your family members need not be enrolled in Nova Classical Academy's health plan, only you, the employee must be enrolled in order to use Nice for your entire household.

WHAT IS INCLUDED:

- Video visits: Secure online video chat. Over 60% of issues can be resolved by video.
- Home visits: If the condition requires a lab test, X-ray or in-person examination, a provider will come to your home, often the very same day.
- Prescriptions: Click **here** for the list of 550+ medications a nice nurse can prescribe to you, for free!
- Physical Therapy (new in 2021)

NEW IN 2021:

★ Nice healthcare offers 550+ FREE medications. Prescriptions are sent to your local pharmacy. Present your Nice Rx card at pick up. Chronic medications delivered by mail.

★ Nice's pharmacy network includes over 65,000 pharmacies including CVS and Walmart as well as local mom & pop pharmacies. Chronic medications can be mailed to you at no cost.

★ Unlimited virtual physical therapy.

Unlimited Virtual Physical Therapy

WHAT IS NICE?

A primary care clinic that comes to you, on your schedule, while spending the time to make sure everything makes sense.

Nice is FREE to you to use however often you need it.

So next time you aren't feeling the best, have a question about a mysterious ache or pain, or just want some wellness advice, think of Nice.

HOURS OF SERVICE – ONLINE VISITS

Monday - Friday 8AM - 7PM

Saturday - Sunday 9AM - 12PM

HOURS OF SERVICE – HOME VISITS

Monday - Friday 9AM - 5PM

Weekend home visits no longer available starting on January 1, 2021

★ You can use Nice for virtual visits even if you are out of state.

★ They can even send a prescription to a local pharmacy wherever you are.

New! Free Physical Therapy at Nice Healthcare

Effective January 1, 2021

Starting in 2021, Nice Healthcare is ofering you **unlimited Physical Therapy for FREE!**

Ask your Nice Healthcare provider if physical therapy is right for you.

How it works

1. **Schedule a chat or video visit in your Nice Healthcare app.** If your provider determines that physical therapy would be the best next step, you'll be referred to a physical therapist.
2. **Once the referral is received, a physical therapist will reach out via the Nice app to schedule an initial consultation.** Physical therapy visits are offered via phone or video.
3. **Unlimited physical therapy visits.** Just like our primary care, you can have as many visits as you need at no cost to you.

Download the Nice Healthcare app for IOS and Android to get started.

BENEFITS MANUAL 2021

Nova Classical Academy

Nice Healthcare

Acute Conditions Nice treats:
Sore throat
Ear concerns (pain, drainage, wax)
Cough, cold, flu, bronchitis
Stomach/digestive pain
Rashes
1st degree burns
Headache
Urinary Tract Infection (UTI)
Expedited Partner Therapy
Sinus infection
Yeast infection
Minor asthma flare
Mononucleosis and other viral illnesses
Hand, foot, mouth
Cold sore
Wart evaluation
Muscle or joint pain / sprains and strains
Pink eye
Bug bite
Suture removal
Athlete's foot
And many more.

Nice Chronic Conditions Nice manages:
High Cholesterol
Hypothyroidism
Diabetes (Type 2)
GERD
High Blood Pressure (non-emergent)
Asthma (mild to moderate)
COPD (mild)
Seasonal Allergies / Allergic Rhinitis
Epi-Pen refills
Eczema
Acne (no Accutane)
Depression (mild-moderate)
Anxiety (mild-moderate/no controlled substances)
Menopause
Anemia (mild)
Constipation
Gout
Osteoporosis (non IV or injectable treatments)
Osteoarthritis
Obesity

Conditions available to manage at extra lab cost:
Vitamin D Deficiency
Sexually transmitted infection

Conditions Nice does not manage:
Anything severe or urgent
Uncontrolled Type 1 diabetes
Fractures that require casting
Severe Hypertension
Hyperthyroidism
Congestive Heart Failure
INR / Warfarin monitoring
Cancer
Pregnancy Management
Chronic Kidney Disease
Hepatitis
Kidney infection
Sutures / stitches or staples
Controlled substances
Allergy shots
Intravenous Medications
Tuberculosis

Wellness / Preventive Options:
Adult physicals (minus genital and breast exams)
Sports physicals
Well child / baby checks (no vaccines)
Contraception
Tobacco / Nicotine Cessation

New in 2021: Physical Therapy
Nice offers unlimited, live access to licensed physical therapists within the Nice Healthcare app. Patients will be referred to a physical therapist by a Nice nurse practitioner provider.

QUESTIONS?

Get started:
www.nice.healthcare/schedule or text '**start nice.free**' to **612.806.0144** to stay up to date.

DID YOU KNOW?

Nice provides 70% of care and prescriptions via chat and/or virtual visit.

HOURS OF SERVICE – ONLINE VISITS

Monday - Friday 8AM - 7PM

Saturday - Sunday 9AM - 12PM

HOURS OF SERVICE – HOME VISITS

Monday - Friday 9AM - 5PM

Weekend home visits no longer available starting on January 1, 2021

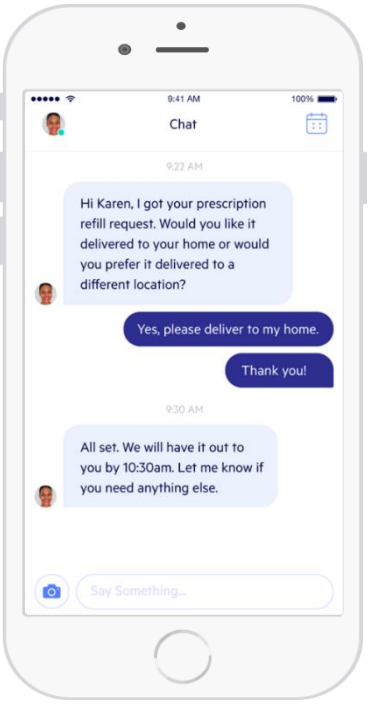
BENEFITS MANUAL 2021

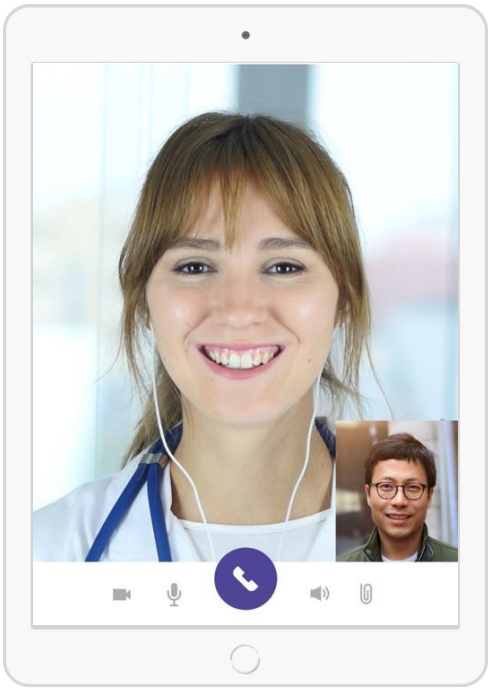
Nova Classical Academy

NICE HEALTHCARE

How to schedule your nice visit

- Using Nice Healthcare if very easy. First setup your account by downloading the Nice Healthcare mobile app or online at www.nice.healthcare/schedule.
- After you have setup your account set up, you can schedule future visits using the Nice Healthcare App. The process starts with a video visit. In-person visits and medication deliveries are then scheduled if needed.
- Within the app, you will need to create separate accounts for each family member.





WHO CAN USE NICE?

Employees under age 65 that are enrolled on one of Nova Classical Academy's health plans automatically have coverage with Nice Healthcare. Even if you have "Employee Only" coverage on the company health plan, all of your family members living in your household at the same residence have access to Nice Healthcare services.

Unfortunately, due to IRS rules, Medicare eligible employees age 65 or older may not use Nice Healthcare.

HOURS OF SERVICE – ONLINE VISITS

Monday - Friday 8AM - 7PM

Saturday - Sunday 9AM - 12PM

HOURS OF SERVICE – HOME VISITS

Monday - Friday 9AM - 5PM

Weekend home visits no longer available starting on January 1, 2021

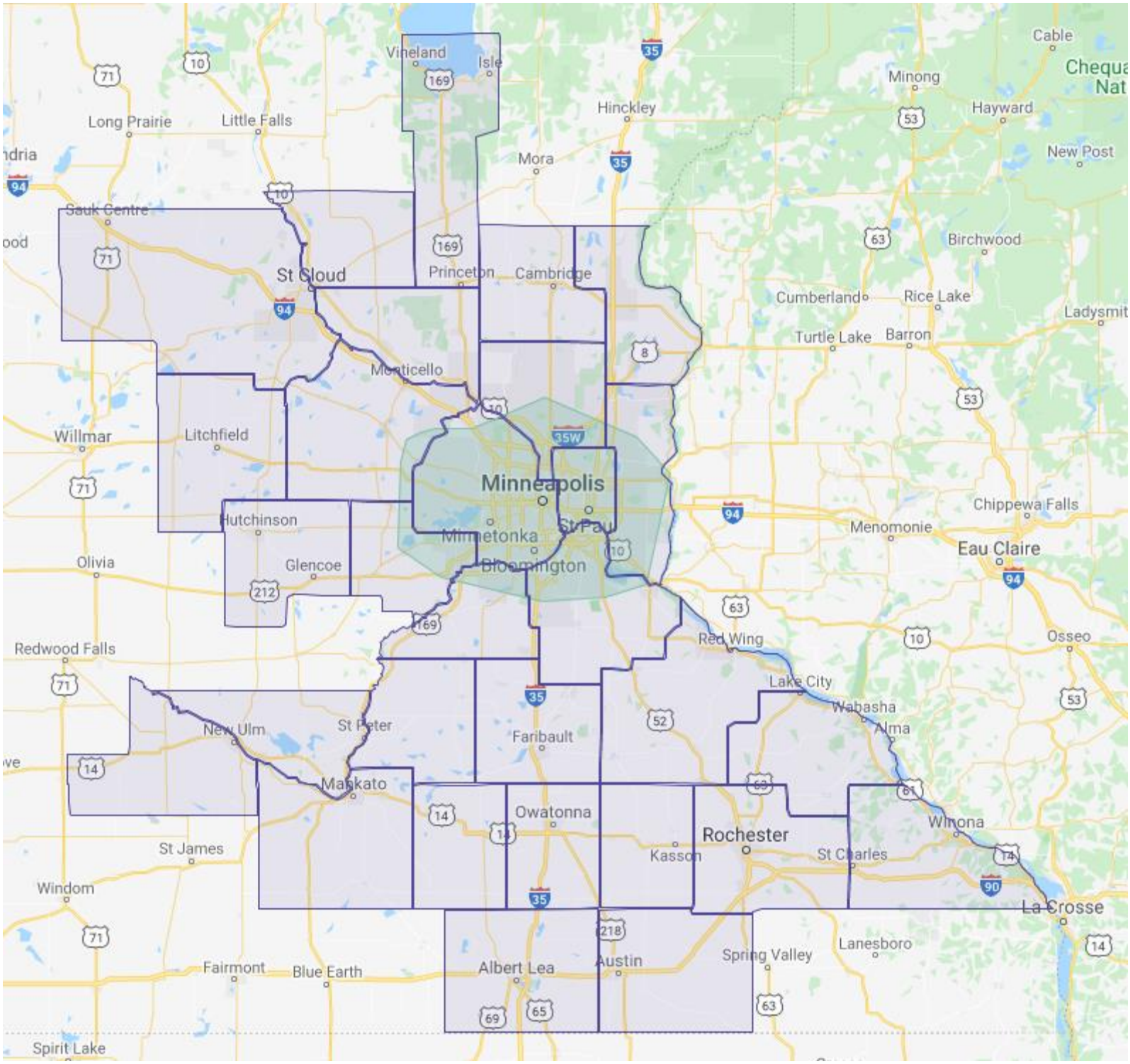
BENEFITS MANUAL 2021

Client Name

NICE HEALTHCARE – EXPANDED IN 2021!

Nice now has a greater coverage area! Employees outside of Nice's outer purple coverage area have an unlimited number of virtual visits available to them. Virtual care visits are available from anywhere in the country.

Click anywhere on the map below to Zoom in for precise coverage areas.



DENTAL PLAN SUMMARY

About the Dental Plan: This is a comprehensive plan for all dental services and covers preventive care at 100% in-network, with no deductible**.** You may use any dentist for your dental services; however, using an in-network provider will reduce your out-of-pocket costs.

Features	In-Network	Out-of-Network
Annual Maximum	$1,500	$1,500
Annual Deductible *Does not apply to preventative and diagnostics*	$25/person $75/family	$25/person $75/family
Diagnostic & Preventive	You pay $0	You pay $0
Basic Restorative Care *Amalgam & Resin Fillings*	You pay 20%	You pay 20%
Oral Surgery *Simple Extractions*	You pay 50%	You pay 50%
Endodontic Therapy *Root Canal*	You pay 20%	You pay 20%
Periodontics *Gum disease*	You pay 20%	You pay 20%
Major Restoratives *Resins, Crowns*	You pay 50%	You pay 50%
Prosthetics and Implants	You pay 50%	You pay 50%
Orthodontics to age 19, $1,000 lifetime maximum	You pay 50%	You pay 50%

Dental Plan Premiums: We contribute to your premiums. These rates are shown monthly and effective January 1, 2021:

Status	Monthly Rates
Employee only	$4.88
Family	$106.31

Please review your plan summary document for more detailed coverage information.

Mutual of Omaha

We offer the dental plan through Mutual of Omaha. Always use an in-network provider to obtain the highest level of benefits.

When accessing care out of network, there are no provider discounts and the member is responsible for the difference between what is charged/billed over the Usual and Customary percentile.

QUESTIONS?

Call customer service at **800-927-9197** or call the phone number on the back of your ID card or visit **www.mutualofomaha.com.**

VOLUNTARY VISION SUMMARY

Our vision plan is offered through Avesis.

About the Vision Plan: This is a comprehensive plan for all visions services. You may use any provider for your vision services; however, using an in-network provider will reduce your out-of-pocket costs.

Features	In-Network	Out-of-Network reimbursement
Eye Exam	You pay $10	Up to $35
Plastic Lenses (1x/12 mos) *Single, Bifocal, Trifocal* *Lenticular* *Progressive*	You pay $25	Up to $25-$50 Up to $80
Lens Options *UV, Tint, Coating* *Polycarbonate* *Anti-Reflective*	You pay $17 You pay $40/$44 You pay $45	Not covered
Frames (1x/24 mos)	You receive up to $130 allowance and then you receive a 20% discount on amounts over $130	Up to $45
Contacts (1x/12 mos) *Elective, in lieu of glasses* *Medically Necessary, in lieu of glasses*	You pay $0 up to $130, 10% discount on balance over $130 Covered in full	Up to $110 Up to $250

Vision Plan Premiums: This is a voluntary plan, meaning you pay 100% of the premiums. Premiums are effective January 1, 2021.

Status	Monthly Rates
Employee only	$7.29
Employee + Spouse	$13.36
Employee + Child(ren)	$14.71
Employee + Family	$19.04

Please review your plan summary document for more detailed coverage information.

avēsis
a GUARDIAN company

Always use an in-network provider to obtain the highest level of benefits.

When accessing care out of network, you receive an amount that the provider will pay up to. You are then responsible for the difference.

Note: This is a voluntary plan, participation is optional. You may waive this coverage if you don't need eyeglasses or contacts.

QUESTIONS?

Call customer service at **855-214-6777** or call the phone number on the back of your ID card or visit **www.avesis.com**.

FLEXIBLE BENEFIT PLAN

We sponsor a flexible benefit plan to help you pay for everyday expenses on a pre-tax basis. The flexible benefit plan benefit helps you pay for everyday medical expenses on a pre-tax basis by:

- **Premiums:** Pre-tax contributions for medical, dental and vision premiums.
- **Medical Flexible Spending Arrangement (FSA):** You can set aside pre-tax contributions for medical, dental and vision expenses not paid by your (or your spouse's) insurance plans up to $2,750 depending on your election. As a reminder, you need to obtain a prescription for over-the-counter medications in order to use your medical FSA dollars for reimbursement (one prescription per OTC med, per year needed).
    - HSA members are limited to deductions for dental and vision expenses only.
- **Dependent care:** You can set aside pre-tax contributions for dependent care expenses up to $5,000 per plan year. No dollars may be carried over into the next plan year.

Participants **must enroll annually** for the plan year effective on January 1, 2021.

Each component of the flexible benefit plan requires a separate election. Funds cannot be moved from one component to another. Contributions cannot be changed unless a qualifying life event occurs and must be made within 30 days of the event. All components are "use it or lose it." No dollars will roll over to the next plan year. This plan is administered by **Further**.

MEDICAL FSA VS HSA

We offer both a Medical Flexible Spending Arrangement and a Health Savings Account. What's the difference?

	Medical FSA	HSA
Health Plan	Use with the copay plan	Use with the HDHP with HSA plan
Ownership	Owned by your employer	Owned by you
Enrollment	Need to re-enroll each year	Enroll once
Access To Your Money	You can access entire annual election amount any time during the year, even if not all the money has been deducted.	You can access to what is deposited to date. If there are not enough funds, you pay out-of-pocket, and reimburse yourself as more funds are deposited.
Use It Or Lose It	Yes, any money left is forfeited.	No, money stays until you spend it
Substantiation	You keep receipts, as may be asked to prove that the money spent was eligible	The account is not "policed", but keep receipts in case of IRS audit.
Option to Change Contributions	You can change election amount if you have a qualifying events, (i.e., marriage, divorce, birth, etc.) or during open enrollment period.	You can change your election amount on a monthly basis, as long as it does not exceed IRS limits, and the amount is in proportion to the number of months you were covered under the HDHP plan.

ANCILLARY PLANS

All benefit-eligible employees are enrolled in life insurance, accidental death & dismemberment (AD&D) and long-term disability (LTD) plans provided by Mutual of Omaha. We pay 100% of the premium for you. You may elect Voluntary Short Term Disability insurance. This plan is paid 100% by you.

LIFE AND AD&D

You are covered for 1x your salary up to $100,000 maximum for the basic life plan. You are also covered at the same amount for the AD&D plan. The original amount of the Life and AD&D benefits will reduce as you age and terminate upon your retirement or termination of employment. Now is a great time to review or update your beneficiary.

VOLUNTARY LIFE INSURANCE AND AD&D

You may elect optional life insurance and accidental death and dismemberment (AD&D) insurance. These plans are paid 100% by you and are intended to supplement the provided Basic Life and AD&D Insurance described above. Evidence of insurability may be required for applications for coverage over the guaranteed issue amounts listed below and for late entrants.

Employee Benefit	Maximum benefit is 5X your annual earnings to the maximum of $500,000. Sold in $10,000 increments. Guaranteed issue amount of $150,000 with no evidence of insurability for new enrollees.
Spouse Benefit	Maximum benefit is $100,000. Sold in $5,000increments, not to exceed 100% of the employee's electedamount. Guaranteed issue amount of $50,000 with no evidenceof insurability required for new enrollees.
Child(ren) Benefit (to age 26)	Benefit is $10,000. This is a guaranteed issue amount.

VOLUNTARY LIFE AND AD&D INSURANCE RATES

The premiums are shown per $10,000 increments, per pay period (24 payroll deductions per year).

Employee/Spouse	Rates
Less than 30	$0.40
30-34	$0.50
35-39	$0.55
40-44	$0.60
45-49	$0.85
50-54	$1.25
55-59	$2.25
60-64	$3.40
65-69	$6.45
70+	$10.40
Child	$1.00

SHORT-TERM DISABILITY

You can receive 60% of your earnings (up to a maximum weekly benefit of $1,000) in the event of a qualifying disability claim. Benefits begin the 8th day of an accident or the 8th day of an illness for a maximum of 12-weeks. Short Term Disability is provided through Mutual of Omaha.

Use the premium factor in the table provided below to calculate your premium for voluntary short term disability coverage, using the example as a guide.

SEMI-MONTHLY PREMIUM CALCULATION		EXAMPLE *(42-year-old employee earning $40,000 a year)*
List your weekly earnings (Maximum is $1,666.67)	$ _____	$ 769.23
Multiply by the premium factor	0.0141000	0.0141000
Your Estimated Semi-Monthly Premium**	$ _____	$ 10.85

*****This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.**

LONG-TERM DISABILITY

You may receive 60% of your earnings up to a maximum monthly benefit of $5,000 in the event of a qualifying disability claim. Benefits may begin after 90 days or after conclusion of STD benefit.

EMPLOYEE ASSISTANCE PROGRAM

You have access to an Employee Assistance Program (EAP) provided by Mutual Of Omaha. This program can help you and your dependents cope with life's everyday, and not-so-everyday, challenges.

Call **800-877-5176** or visit ww.mutualofomaha.com.

NEXT STEPS

HEALTH PLAN

If you would like to enroll, switch your health plan or change your family status, this is the one time during the year you can do so without a qualifying event.

If you are already enrolled in the health plan, you will be automatically re-enrolled at your current coverage status. No forms are needed.

DENTAL AND VISION PLANS

If you would like to enroll, add, change or drop dependent(s), now is the time you are able to do that. If you are currently enrolled and do not have any changes, you will be automatically re-enrolled at your current coverage status. No forms are needed.

HEALTH SAVINGS ACCOUNTS

New HSA participants need to complete paperwork to set up an account.

FLEXIBLE BENEFIT PLAN

A form must be filled out and returned to participate.

LIFE, AD&D AND LTD PLANS

All benefit-eligible employees are enrolled in these plans. Now is a good time to review your beneficiary designation for your life and AD&D policies.

VOLUNTARY LIFE, AD&D AND STD PLANS

To enroll in these plans, forms must be filled out and returned. Evidence of insurability is required if you are requesting amount above the Guarantee Issue.

QUESTIONS? NEED FORMS?

Contact Kriscel Estrella **651-209-6320 ext. 306**, **kestrella@novaclassical.org.**

CARRIER QUICK LINKS

Health Plan

Preferred One
763-847-4477
800-997-1750
www.preferredone.com

Dental Plan

Mutual of Omaha
800-927-9197
www.mutualofomaha.com

Vision Plan

Avesis
855-214-6777

www.avesis.com

Flexible Benefit Plan

Further
800-859-2144
651-662-5065
www.hellofurther.com

Ancillary Plans

Mutual of Omaha
800-877-5176
www.mutualofomaha.com

WHAT ARE THESE GOVERNMENT NOTICES ALL ABOUT?

Following this page are several notices that the federal government requires us to give individuals who are covered under our group health plan(s). The purpose of these notices is to inform you of certain rights you and your family may have under federal law. In addition to rights under federal law, you may have rights under state law.

You may find it helpful to review this information as you make your benefit enrollment decisions. Please keep this information with your other written plan materials.

1. HIPAA Portability Notice
2. Initial COBRA Notice
3. Notice of Exchange
4. Medicare Part D Coverage Notice
5. HIPAA Notice of Privacy Practices
6. CHIP Notice
7. WHCRA Notice
8. Grandfathered Plan Notice

This document provides information about some of the key employee benefit notice requirements. This document should not be construed as providing legal advice, and does not replace the need to discuss benefit notices and other matters with their benefit and compliance specialists.

HIPAA PORTABILITY NOTICE

Our records show that you are eligible to participate in the company's Group Health Plan (to actually participate, you must complete an enrollment form and pay your share of the premium). A federal law called HIPAA requires that we notify you about some important provisions in the plan.

Special enrollment rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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.

If you are declining enrollment because you and/or your dependents are covered under a Medicaid plan or state Child Health Plan (CHIP) and that coverage is terminated due to a loss of eligibility, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within **60 days** after the date that termination of such coverage occurred and meet certain other important conditions described in the Summary Plan Description.

If you and/or your dependents are determined to be eligible under a state's Medicaid plan or state Child Health Plan (CHIP) for premium subsidy assistance, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days of the determination of eligibility for premium subsidy assistance for you or your dependents and meet certain other important conditions as described in the respective Summary Plan Description.

To request special enrollment or obtain more information, contact Kriscel Estrella, Plan Administrator, **651-209-6320 ext. 306, kestrella@novaclassical.org**.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. COBRA (and the description of COBRA coverage contained in this notice) applies only to group health plan benefits and not to any other benefits offered by your employer.

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 , your spouse, and dependent children 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, join a spouse's group health plan, or to obtain coverage through a public health program (e.g., Medicare or Medicaid). From time to time, governmental programs may be available to you to help you pay monthly premiums or save on out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage unless the Plan sponsor has chosen to subsidize the cost of 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. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, then the divorce or legal separation may be considered a qualifying event for you even if your coverage was reduced or eliminated before the divorce or separation.

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 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?
When the qualifying event is the end of employment, a reduction in hours of employment, or the death of the employee, the Plan will offer COBRA continuation coverage to qualified beneficiaries. You do not need to notify your employer of any of the events listed in the last sentence.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. You must provide this notice to: Kriscel Estrella, 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 and spouses (if the spouse is a qualified beneficiary) may elect COBRA continuation coverage on behalf of all of the qualified beneficiaries, 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. If the employer offers a health Flexible Spending Account, COBRA coverage under a health Flexible Spending Account can last only until the end of the year in which the qualifying event occurred.

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 a qualified beneficiary is determined by Social Security to be disabled and notifies the employer in a timely fashion, all of the qualified beneficiaries in your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability would have to have started at some time before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months), as described above.

The disability extension is available only if you notify the employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's designated form (you may obtain a copy of this form from the employer at no charge). **If these procedures are not followed or if the notice is not provided to the employer during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving COBRA continuation coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA continuation coverage 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; 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. This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.

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 individual health insurance carriers, Medicaid, Medicare, 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.

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).

Keep your plan informed of address changes

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

Plan contact information
Kriscel Estrella 651-209-6320 ext. 306, kestrella@novaclassical.org

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Part A: General information

When key parts of the health care law took effect in 2014, there began 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 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 began in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

How can I get more information?
For more information about your coverage offered by your employer, please check your summary plan description or contact **Kriscel Estrella** **651-209-6320 ext. 306, kestrella@novaclassical.org**.

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. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Part B: Information about health coverage offered by your employer

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

3. Employer name: Nova Classical Academy
4. Employer Identification Number (EIN): 26-0035570
5. Employer address: 1455 Victoria Way
6. Employer phone number: 651-209-6320
7. City: St. Paul
8. State: MN
9. ZIP code: 55102
10. Who can we contact about employee health coverage at this job? Kriscel Estrella
11. Phone number (if different from above): 651-209-6320 ext. 306
12. Email address: kestrella@novaclassical.org

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

As your employer, we offer a health plan to:

☒ All employees who are scheduled to work 30 or more hours per week
☐ Some employees:

With respect to dependents:

☒ We do offer coverage.
☐ We do not offer coverage.
☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important notice from Nova Classical Academy about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Nova Classical Academy 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. Nova Classical Academy has determined that the prescription drug coverage offered by the Preferred One Health Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through 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.

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

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

For more information about this notice or your current prescription drug coverage…
Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it if this coverage through Nova Classical Academy 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 800-MEDICARE (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 800-772-1213 (TTY 800-325-0778).

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

Date:	01/01/2021
Name of Entity/Sender:	Nova Classical Academy
Contact--Position/Office:	Kriscel Estrella Director of HR
Address:	1455 Victoria Way St Paul, MN 55102
Phone Number:	651-209-6320

NOTICE OF PRIVACY PRACTICE

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

Your rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our uses and disclosures
We may use and share information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records
- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **877-696-6775** or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

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

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

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

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: a doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: we use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: we share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the department of health and human services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

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

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

CHANGES TO THE TERMS OF THIS NOTICE

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

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 **877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ARKANSAS – Medicaid**
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**CALIFORNIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	Website: **https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx** Phone: 961-440-5676

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid – Medicaid and CHIP (Hawki)**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+:https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	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
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884
GEORGIA – Medicaid	**KENTUCKY – Medicaid**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
INDIANA – Medicaid	**LOUISIANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	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	**NEVADA – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 TTY: Main relay 711	Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900
MASSACHUSETTS – Medicaid and CHIP	**NEW HAMPSHIRE – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MINNESOTA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	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
MISSOURI – Medicaid	**NEW YORK – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MONTANA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NEBRASKA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855 632-7633 Lincoln: 402 473-7000 Omaha: 402 595-1178	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

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

To see if any other states have added a premium assistance program since **July 31, 2020**, or for more information on special enrollment rights, contact either:

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

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

NOTICE OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

On October 21, 1998, the federal government enacted the Women's Health and Cancer Rights Act. This law requires that all group health plans that provide coverage for mastectomies must also provide coverage for breast reconstruction surgery in connection with that mastectomy. This memo is intended to provide participants and beneficiaries with notice of their rights under the Women's Health and Cancer Rights Act.

Participants and beneficiaries who receive benefits under the group health plan in connection with a mastectomy and elect breast reconstruction surgery in connection with that mastectomy are entitled to coverage for that reconstruction in a manner determined in consultation with the attending physician and the patient. Such coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits may be subject to deductibles and coinsurance limitations consistent with those established for similar benefits under the group health plan.

Please contact the Human Resources Department or the company's health insurance carrier directly for more information on your rights under the Women's Health and Cancer Rights Act.

NOTES

This Focus on Benefits provides a brief summary of your benefits. It does not contain all of the details described in the official plan documents and contracts. If there is any discrepancy between what is summarized here or any verbal descriptions of the plan and the official plan documents and contracts, the plan documents and contracts will govern.

Your employer reserves the right to change, amend, suspend, or terminate any or all of the plans described in the guide at any time and for any reason. This Focus on Benefits is not a contract, and participation in any of the plans does not guarantee employment.

Information provided by USI Insurance Services.