Lewis Central Community School District

Full-Time School-Year Staff Benefit Summary
2023-2024 Plan Year

CHIP NOTICE

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the following page, 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, dial **1-877-KIDS NOW**, or visit **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 a state listed below, you may be eligible for assistance paying your employer health plan premiums. The list of states is current as of July 31, 2022. Contact your State for further information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

State	Website/E-mail	Phone
Alabama (Medicaid)	**http://www.myalhipp.com/**	1-855-692-5447
Alaska (Medicaid)	*Premium Payment Program:* **http://myakhipp.com/** *Medicaid Eligibility:* **https://health.alaska.gov/dpa/Pages/default.aspx** *E-mail:* **CustomerService@MyAKHIPP.com**	1-866-251-4861
Arkansas (Medicaid)	**http://myarhipp.com/**	1-855-692-7447
California (Medicaid)	**http://dhcs.ca.gov/hipp** **hipp@dhcs.ca.gov**	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	*Medicaid:* **https://www.healthfirstcolorado.com/** *CHIP:* **https://www.colorado.gov/pacific/hcpf/child-health-plan-plus** *HIBI:* **https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program**	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711

State	Website/E-mail	Phone
Florida (Medicaid)	**https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**	1-877-357-3268
Georgia (Medicaid)	*HIPP:* **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** *CHIPRA:* **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	*Healthy Indiana Plan for low-income adults 19-64:* **http://www.in.gov/fssa/hip/** *All other Medicaid:* **https://www.in.gov/medicaid**	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	*Medicaid:* **https://dhs.iowa.gov/ime/members** *CHIP:* **http://dhs.iowa.gov/Hawki** *HIPP:* **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	**https://www.kancare.ks.gov/**	1-800-792-4884
Kentucky (Medicaid and CHIP)	*Medicaid:* **https://chfs.ky.gov** *KI-HIPP:* **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.apsx** *KI-HIPP E-mail:* **KIHIPP.PROGRAM@ky.gov** *KCHIP:* **https://kidshealth.ky.gov/Pages/index.aspx**	 1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	**www.medicaid.la.gov** **www.ldh.la.gov/lahipp**	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	**https://www.maine.gov/dhhs/ofi/applications-forms**	*Enroll:* 1-800-442-6003 *Private HIP:* 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	**https://www.mass.gov/masshealth/pa**	1-800-862-4840 TTY: 617-886-8102
Minnesota (Medicaid)	**https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**	1-800-657-3739
Missouri (Medicaid)	**http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana (Medicaid)	**http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** **HHSHIPPProgram@mt.gov**	1-800-694-3084
Nebraska (Medicaid)	**http://www.ACCESSNebraska.ne.gov**	1-855-632-7633 *Lincoln:* 402-473-7000 *Omaha:* 402-595-1178
Nevada (Medicaid)	**http://dhcfp.nv.gov/**	1-800-992-0900
New Hampshire (Medicaid)	**https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**	603-271-5218 or 1-800-852-3345, ext. 5218
New Jersey (Medicaid and CHIP)	*Medicaid:* **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** *CHIP:* **http://www.njfamilycare.org/index.html**	*Medicaid:* 609-631-2392 *CHIP:* 1-800-701-0710
New York (Medicaid)	**https://www.health.ny.gov/health_care/medicaid/**	1-800-541-2831
North Carolina (Medicaid)	**https://medicaid.ncdhhs.gov/**	919-855-4100
North Dakota (Medicaid)	**http://www.nd.gov/dhs/services/medicalserv/medicaid/**	1-844-854-4825
Oklahoma (Medicaid and CHIP)	**http://www.insureoklahoma.org**	1-888-365-3742
Oregon (Medicaid)	**http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html**	1-800-699-9075
Pennsylvania (Medicaid)	**https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx**	1-800-692-7462
Rhode Island (Medicaid and CHIP)	**http://www.eohhs.ri.gov/**	1-855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina (Medicaid)	**https://www.scdhhs.gov**	1-888-549-0820
South Dakota (Medicaid)	**http://dss.sd.gov**	1-888-828-0059
Texas (Medicaid)	**http://gethipptexas.com/**	1-800-440-0493
Utah (Medicaid and CHIP)	*Medicaid:* **https://medicaid.utah.gov/** *CHIP:* **http://health.utah.gov/chip**	1-877-543-7669
Vermont (Medicaid)	**http://www.greenmountaincare.org/**	1-800-250-8427
Virginia (Medicaid and CHIP)	**https://www.coverva.org/en/famis-select** **https://www.coverva.org/en/hipp**	1-800-432-5924
Washington (Medicaid)	**https://www.hca.wa.gov/**	1-800-562-3022
West Virginia (Medicaid)	**https://dhhr.wv.gov/bms/** **http://mywvhipp.com/**	*Medicaid:* 304-558-1700 *CHIP:* 1-855-699-8447
Wisconsin (Medicaid and CHIP)	**https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**	1-800-362-3002
Wyoming (Medicaid)	**https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**	1-800-251-1269

DISCLAIMER

The intent of this summary is to briefly highlight your benefits and NOT to replace your insurance contracts or booklets. The information has been compiled into summary form to outline the benefits offered by your company.

If this benefit summary does not address your specific benefit questions, please refer to the Customer Service Contact page of this booklet. This page will provide you with the information you need to contact the specific insurance carriers and/or your Human Resources Department for additional assistance.

The information provided in this summary is for comparative purposes only. Actual claims paid are subject to the specific terms and conditions of each contract. This benefit summary does not constitute a contract.

The information in this booklet is proprietary. Please do not copy or distribute to others.

Contained within this document is your annual Medicare Part D notice as required by the Centers for Medicare & Medicaid. Please see the table of contents for page number.

Created by Holmes Murphy & Associates for Lewis Central CSD.

HOLMES MURPHY

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HOLMES MURPHY

2023 BENEFITS OPEN ENROLLMENT

This is your time to review the information provided in the Employee Benefit Summary and determine which benefit plans you want to enroll in. To make a change in your benefit elections outside of the open enrollment window, you must have a qualifying life event, such as marriage, birth of a baby, loss of coverage, etc. Please contact HR within 30 days if you experience a qualifying life event and need to make a change to your benefit elections.

WHAT BENEFITS AM I ELIGIBLE TO ENROLL IN?

Medical and Prescription Drugs – Gravie / Aetna
- Deductible and out-of-pocket maximum run on the calendar year, January through December.
- The District will offer one medical plan to Full-Time School Year staff, a $5,000/$10,000 out-of-pocket maximum plan.

Flexible Spending Account (FSA) – iSolved
- The Health Care FSA maximum contribution amount for 2023 is $3,050.
- The Health Care FSA includes a rollover feature, in which $610 can roll into the next plan year *(not available for Dependent Care FSA)*. Any unused Health Care FSA dollars over $610, and any amount of unused Dependent Care FSA dollars, will be forfeited by the employee.

Dental – Delta Dental
- Deductible and annual benefit maximum run on the calendar year, January through December.

Voluntary Vision – VSP

Voluntary Life / Accidental Death & Dismemberment (AD&D) – Madison National
- **Please note**, if your age this year puts you into a new age bracket, you may see an increase in Voluntary Life premium.
- Always remember to review your beneficiary designation each year and update as necessary. If you need to update your beneficiary information, please contact HR.

Voluntary Accident and Critical Illness – Allstate

Voluntary Universal Life – Trustmark

WHAT BENEFITS AM I AUTOMATICALLY ENROLLED IN?

Basic Life / Accidental Death & Dismemberment (AD&D) – Madison National
- Always remember to review your beneficiary designation each year and update as necessary. If you need to update your beneficiary information, please contact HR.

Long Term Disability (LTD) – Madison National

Employee Assistance Program (EAP) – Employee & Family Resources (EFR)
- All employees have access to the EAP as a resource for their personal needs and their family's needs.
- Comprehensive EAP including 3 in-person counseling or telephonic life coaching sessions per year with masters-level clinicians and/or licensed counselors. Unlimited phone-based support is also available.
- 24/7/365 national call center, guidance and resources for everything from life coaching, identity theft resolution services, financial consultations, and childcare referrals for you and your family!
- Completely free and 100% confidential to employees.

2023 ENROLLMENT GUIDELINES

WHEN DOES THE NEW PLAN YEAR GO INTO EFFECT?

The plan year for benefits runs from July 1, 2023, through June 30, 2024. All elections you make (or allow to roll-over) during open enrollment with the exception of the optional accident, critical illness and universal life plans will be effective July 1, 2023 and will continue through June 30, 2024. The optional plans will be effective September 1, 2023 and run through August 31, 2024.

HOW DO I COMPLETE OPEN ENROLLMENT?

IMPORTANT – Lewis Central CSD will have an **active** enrollment this year. This means that Full-Time School Year staff must actively elect or waive all benefits for July 1, 2023. You may also want to check your profile and dependent information to verify contact information and student status.

Ways to Complete 2023 Benefit Open Enrollment:

Elections will be due no later than May 29, 2023:

- **Call Center: Call 844-708-5600 (Hours are 8am-5pm CST on Monday, Wednesday, Thursday, Friday, and 8am-7pm CST on Tuesday)**
  - Speak directly to a Benefit Counselor to assist with benefit questions and/or complete your enrollment
- **Website (Self-Service)**: Go to: https://allstate.benselect.com
  - Login using your Social Security Number (no dashes) OR your full Employee ID
    - Example: GTMXXXXXX or Y0QXXXXXX
  - You PIN is the last 4 of your Social Security Number followed by the last 2 digits of your birth year, no spaces
    - Example: Last 4 of SSN = 9999, DOB = 1/2/1975 then PIN = 999975

Once you have made your elections, you will not be able to change them until the next open enrollment period, unless you have a qualified change in status.

Details on all benefits listed above provided in the Employee Benefit Summary. These summaries and the Annual Notices are available on the District website under lewiscentral.org/hr "Benefit Insurance Information."

2023 Annual Notices and medical plan Summary of Benefits and Coverage (SBC) documents can be accessed during Open Enrollment while logged into the online self-service website under Document Library or anytime at

https://www.gravie.com/2023sbclewiscentralcsd/

WHAT IF I NEED TO MAKE CHANGES OUTSIDE OF OPEN ENROLLMENT?

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status, reduction in hours, or marketplace open enrollment. See HIPAA Special Enrollment Rights in the Annual Notices packet for notification requirements.

2023 Per Pay Period Premiums

Basic Coverages	Per Pay Period Premium	Employee Pays Per Pay Period	District Pays Per Pay Period
Out-of-Pocket Maximum (OPM)			
$5,000 / $10,000 Medical Plan			
Single:	$393.60	$63.60	$330.00
Employee/Spouse:	$722.40	$392.40	$330.00
Employee/Child(ren)	$641.40	$311.40	$330.00
Family:	$970.20	$640.20	$330.00
Dental			
Single:	$18.58	$0.00	$18.58
Family:	$47.14	$28.56	$18.58
Life and AD&D (Employee only)	N/A	0%	100%
Long-Term Disability (LTD)	N/A	0%	100%
Flexible Spending Account (Fees only)	N/A	0%	100%
Voluntary Products	**Per Pay Period Premium**	**Employee Pays Per Pay Period**	**District Pays Per Pay Period**
Voluntary Vision			
Single:	$6.74	100%	0%
Employee/Spouse:	$10.79	100%	0%
Employee/Children:	$11.01	100%	0%
Family:	$17.75	100%	0%
Voluntary Life and AD&D:	See VTL Rate Page	100%	0%
Individual Products:	Varies	100%	0%

**Employee deductions will occur over 20 pay periods, from 9/1/2023-6/14/2024.*

Lewis Central CSD

July 1, 2023

Comfort $5,000 OPM

BENEFIT OVERVIEW	In-Network	Out-of-Network
Deductible		
Single	$0	$10,000
Family	$0	$20,000
Coinsurance	0%	50%
Out-of-Pocket Maximum		
Single	$5,000	No Limit
Family	$10,000	No Limit
BENEFIT HIGHLIGHTS		
Physician Visit	No Charge	Deductible, 50% Coinsurance
Preventive Services	Covered at 100%	Deductible, 50% Coinsurance
Urgent Care	No Charge	Deductible, 50% Coinsurance
Emergency Physician	$250 Copayment	$250 Copayment
Hospital Services		
Inpatient	No Charge after meeting OPM	Deductible, 50% Coinsurance
Outpatient	No Charge after meeting OPM	Deductible, 50% Coinsurance
Physician Charges	No Charge after meeting OPM	Deductible, 50% Coinsurance
PRESCRIPTION DRUGS		
Generic Rx	No Charge	Not Covered
Preferred Brand Rx	$75 Copayment	Not Covered
Non-Preferred Brand Rx	No Charge after meeting OPM	Not Covered
Specialty Rx	No Charge after meeting OPM	Not Covered
Mail Order Rx	2 Copayments	Not Covered

Note: This is a summary of benefits provided by the plans. Refer to the carrier's descriptive material for a full discussion of benefits and rates. This information is proprietary. Please do not copy or distribute to others.

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, visit www.gravie.com/. For 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 855.451.8365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers: $5,000 individual/$10,000 family. Out-of-network providers: $10,000 individual/$20,000 family.	See the Common Medical Events chart below for a summary of coverage provided by this plan. For some services, a copayment or payment toward the out-of-pocket may apply.
Are there services covered before you meet your deductible?	Yes. In-network preventive care services, office visits (primary and specialty care), on-line care through Gravie's telemedicine service provider, labs and related imaging work, urgent care visits and generic prescriptions are covered at no cost. The no cost portion only applies to labs/imaging related to the office visit.	This plan covers some items and services even if you haven't met the deductible amount. For example, this plan covers certain preventive services without cost-sharing. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/. Copay/coinsurance may apply to some services.
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?	In-network providers: $5,000 individual / $10,000 family ($5,000 per family member). Out-of-network providers: Not applicable. For ease of reference, your out-of-pocket maximum will be referred to as OOPM through this document.	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. The in-network OOPM is the same as the deductible. There is no out-of-pocket limit for out-of-network providers.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	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.aetna.com/asa or call 855.451.8365 for a list of 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 can see the specialist you choose without a referral.

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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 In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	50% coinsurance after deductible	Access to lower-cost online care services may be available through Gravie's telemedicine service provider. Dialysis, chemotherapy, radiation and certain injectable drugs are not free when administered at an office or clinic. For more information, you can contact Gravie Customer Service at 855.451.8365.
	Specialist visit	No charge	50% coinsurance after deductible	Access to lower-cost online care services may be available through Gravie's telemedicine service provider. Dialysis, chemotherapy, radiation and certain injectable drugs are not free when administered at an office or clinic.
	Preventive care/screening /immunization	No charge	50% coinsurance after deductible	Some over-the-counter (OTC) drugs can be obtained with a prescription at the preventive level of coverage.
If you have a test	Diagnostic test (x-ray, blood work)	Office/Clinic: No charge. Hospital: No charge after OOPM	50% coinsurance after deductible	No charge services limited to tests done within office or clinic. OOPM applies to tests associated with a hospitalization. Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	Office/Clinic: No charge. Hospital: No charge after OOPM	50% coinsurance after deductible	No charge services limited to tests done within office or clinic. OOPM applies to tests associated with a hospitalization. Prior authorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 855.451.8365	Generic drugs	Retail: No charge. Mail: No charge.	Not covered	Retail and mail order available up to 90-day supply.
	Preferred brand drugs	Retail, 30-day supply: $75 copay Retail,90-day supply: $150 copay Mail, 90-day supply: $150 copay	Not covered	Retail and mail order available up to 90-day supply.
	Non-preferred brand drugs	Retail and mail: No charge after OOPM	Not covered	Retail and mail order available up to 90-day supply.
	Specialty drugs	Retail and mail: No charge after OOPM	Not covered	Retail and mail order available up to 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after OOPM	50% coinsurance after deductible	Prior authorization may be required for certain outpatient surgery procedures.
	Physician/surgeon fees	No charge after OOPM	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room services	$250 copay	$250 copay	Services in connection with an Emergency are covered at in-network level.
	Emergency medical transportation	No charge after OOPM	No charge after OOPM	Services in connection with an Emergency are covered at in-network level.
	Urgent care	No charge	50% coinsurance after deductible	None

* For more information about limitations and exceptions, see the Plan or policy document at www.gravie.com

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after OOPM	50% coinsurance after deductible	Prior authorization may be required
	Physician/surgeon fees	No charge after OOPM	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office/Clinic: No charge. Hospital: No charge after OOPM	50% coinsurance after deductible	Access to lower-cost online care services may be available through Gravie's telemedicine service provider
	Inpatient services	No charge after OOPM	50% coinsurance after deductible	Prior authorization may be required
If you are pregnant	Office visits	No charge	50% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance, deductible may apply.
	Childbirth/delivery professional services	No charge after OOPM	50% coinsurance after deductible	None
	Childbirth/delivery facility services	No charge after OOPM	50% coinsurance after deductible	Prior authorization may be required
If you need help recovering or have other special health needs	Home health care	No charge after OOPM	50% coinsurance after deductible	100 visit limit per year.
	Rehabilitation services	Office/Clinic: No charge. Hospital: No charge after OOPM	50% coinsurance after deductible	Access to no-cost online programs and services may be available through Gravie's digital physical therapy partner. Prior authorization is recommended for **other** physical, occupational, and speech therapy.
	Habilitation services	Office/Clinic: No charge. Hospital: No charge after OOPM	50% coinsurance after deductible	Access to no-cost online programs and services may be available through Gravie's digital physical therapy partner. Prior authorization is recommended for **other** physical, occupational, and speech therapy.
	Skilled nursing care	No charge after OOPM	50% coinsurance after deductible	120 days per member per year. Prior authorization may be required
	Durable medical equipment	No charge after OOPM	50% coinsurance after deductible	Limits may apply. Prior authorization may be required.
	Hospice service	No charge after OOPM	50% coinsurance after deductible	Prior authorization may be required.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance after deductible	Limit of 1 routine exam per year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery (unless determined to be reconstructive)
- Dental care (Adults)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (except certain conditions)
- Weight loss programs (except preventive obesity counseling/screening)

* For more information about limitations and exceptions, see the Plan or policy document at www.gravie.com

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Infertility treatment	• Private-duty nursing (Inpatient Only)
• 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 the agency is the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /www.dol.gov/ebsa/healthreform. 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact Gravie Customer Service at 855.451.8365 or the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /www.dol.gov/ebsa/healthreform.

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 Standards? 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 763.847.4477 / 800.997.1750]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 763.847.4477 / 800.997.1750]

[Chinese (中文): 如果需要中文的助 763.847.4477 / 800.997.1750]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 763.847.4477 / 800.997.1750]

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

* For more information about limitations and exceptions, see the Plan or policy document at www.gravie.com

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	$5,000
Specialist copay	$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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or Exclusions	$60
The total Peg would pay is	**$5,060**

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

The plan's overall deductible	$5,000
Specialist copay	$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	$800
Copayments	$1000
Coinsurance	$0
What isn't covered	
Limits or Exclusions	$30
The total Joe would pay is	**$1,830**

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

The plan's overall deductible	$5,000
Specialist copay	$0
Hospital (facility) copay	$250
Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic tests (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1200
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or Exclusions	$0
The total Mia would pay is	**$1,500**

The plan would be responsible for the other costs of these EXAMPLE covered services.

COMFORT™

Health benefits you can actually use

Comfort provides 100% coverage on most common, in-network healthcare services at a cost comparable to most traditional group health plans.

No hidden costs. No surprise bills.

No-Cost Services

- Preventive care
- Primary care
- Specialist visit
- Urgent care visit
- Labs & imaging
- Generic prescriptions
- Online care
- Mental health care
- And more

Other Services

- Emergency room
  $250 copay
- Brand name prescriptions
  $75 copay
- Non-preferred brand name prescriptions
  $100 copay or no cost after out-of-pocket max*
- Specialty prescriptions
  $125 copay or no cost after out-of-pocket max*
- Hospital surgery/procedure
  No cost after out-of-pocket max

Check your benefits summary for specific details

Get care when you need it

Emma hurts her ankle on a run. She visits her doctor for a check-up and an x-ray.

COMFORT™	$0
Traditional Plan	~$450

Sue takes a generic prescription daily.

COMFORT™	$0
Traditional Plan	~$120 annually

Roger is feeling under the weather. He heads to the doctor for a check-up, and his doctor orders blood work.

COMFORT™	$0
Traditional Plan	~$30 copay & ~$220 blood work

The network

aetna Aetna Signature Administrators®

Gravie partners with Aetna Signature Administrators to provide broad access to quality coverage. Aetna Signature Administrators offers one of the nation's leading Preferred Provider Organizations (PPO) – a network of physicians, clinics, hospitals, and other health care providers who have agreed to deliver quality, cost-effective health care services.

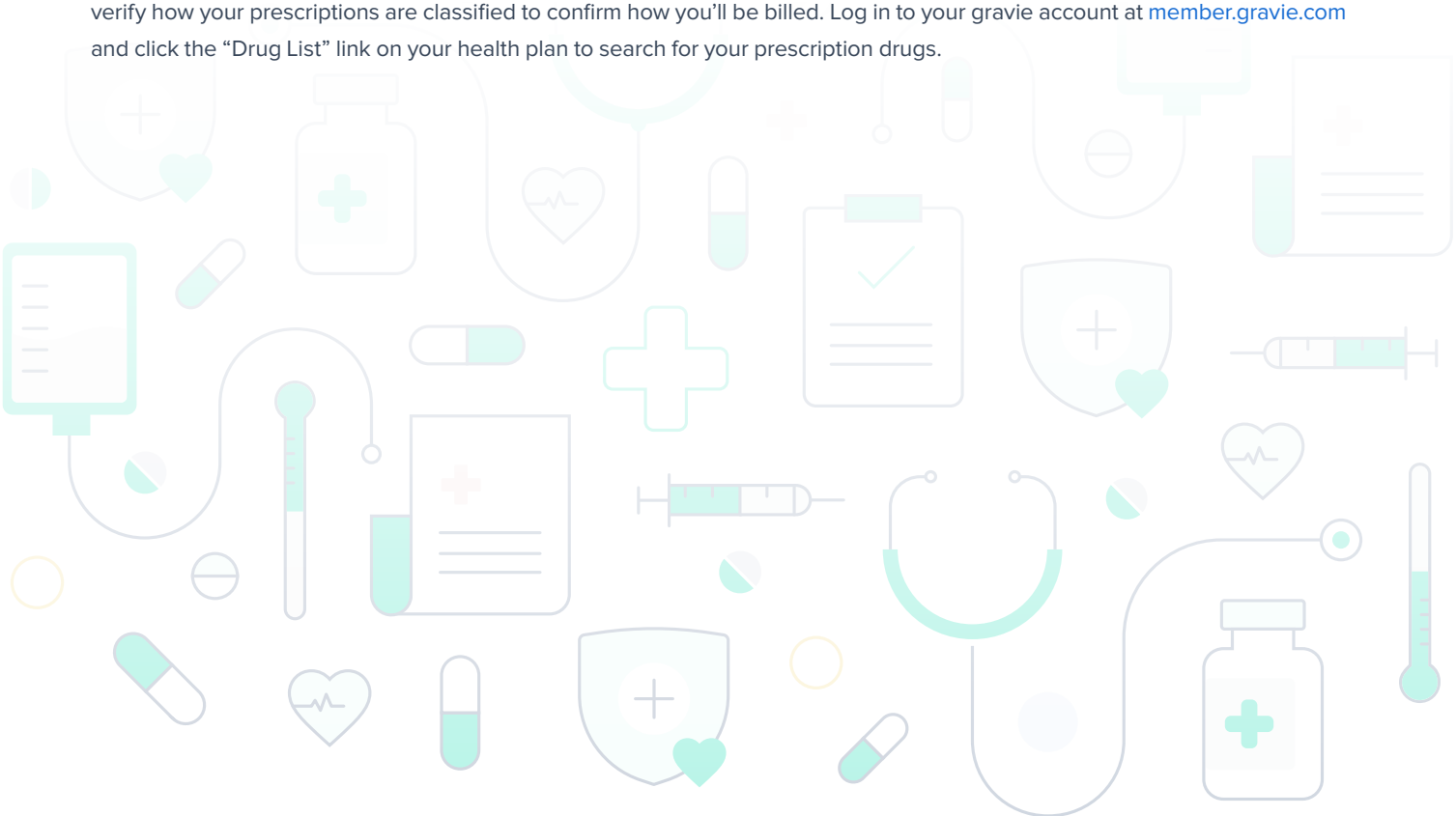
With the Aetna Signature Administrators PPO network, you'll have access to:

- Over 1.2 million participating doctors
- 8,700 hospitals
- Competitive discounts

Remember, staying in-network is important for avoiding any unexpected charges. Before receiving care you can easily search for doctors, specialists, clinics, and more. All you need to do is log in to your account at member.gravie.com and click the "Doctors" link from your health plan.

Traveling? We've got you covered. Wherever you go in the US, you'll have access to a broad PPO network. For details on your travel coverage, contact Gravie Care.

Your generic drugs are 100% covered. For preferred brand, non-preferred brand, and specialty drugs you'll want to look up and verify how your prescriptions are classified to confirm how you'll be billed. Log in to your gravie account at member.gravie.com and click the "Drug List" link on your health plan to search for your prescription drugs.



Plan perks

Gravie partners with health and wellness industry leaders to give you access to a suite of digital services that aim to enhance your health and wellness journey.

For many Gravie health plan members, these services are included at no additional cost.

Teladoc HEALTH

Gravie health plan members have access to virtual care, including general medicine, dermatology and mental health (18+) through Teladoc Health, the world leader in whole-person virtual care. Mental health care includes clinical services such as psychiatry and therapy visits, and non-clinical services such as mental health coaching and digital programs. Now, members can access the care they need whenever and wherever it's convenient for them.

Cost sharing may apply depending on plan type. Check your benefits summary for more information.

FITON × peerfit

Gravie health plan members 18 years of age and over get unlimited access to FitOn's library of 30K+ virtual classes, including cardio, HIIT, yoga, pilates, meditation, dance, and barre, as well as nutrition guides, meal plans, fitness courses and challenges, and more. In-person fitness perks are available to qualifying members through Peerfit. Gravie's fitness partners removes barriers that often prevent members from achieving a healthier lifestyle through diet and exercise.

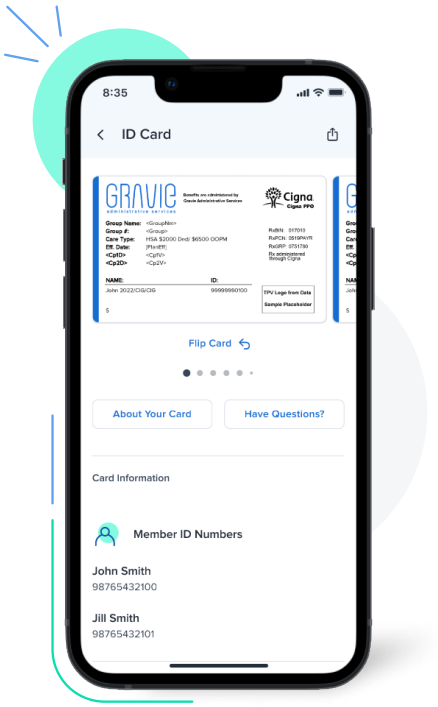
sword

Gravie Health members (13+) have access to Sword - a clinical-grade digital physical therapy program which helps members overcome back, joint, and muscle pain through personalized care from licensed physical therapists and innovative sensor-based technology.

Gravie mobile app

All your favorite Gravie benefits in one simple place.

Use the Gravie app from anywhere to get the care you need, when you need it.



App features:

- **Access your digital ID** card on the spot
- **See what's covered** by your plan
- **Find in-network** providers, clinics, pharmacies, and more near you
- **Review claims** and track expenses throughout the year
- **Connect with Gravie Care**™ — licensed experts available to answer all your health benefits questions

Members enrolled in Comfort can view the list of no-cost services — including primary care, mental health care, specialist visits, labs & imaging, generic drugs, and more.

Download the app by visiting the App Store or Google Play

Download on the App Store

GET IT ON Google Play

App features may vary based on a variety of eligibility and enrollment factors.

www.gravie.com

Gravie account

Easily find care

Our search tool makes it easy to find the in-network care you need — you can filter by location, specialty, and more. Need to check if a prescription is covered? You can search for that too!

Access your digital ID card

Forgot your ID card? No problem. All you need to do is log in to your Gravie account to view your digital ID card. If you ever need a replacement, you can easily print out a new copy

Track your out of pocket max

It's important to know where you stand. Log in to your Gravie account to keep track of individual and family progress towards your out of pocket max.

Review your claims

To see what costs are being counted towards your totals, view your medical and pharmacy claims and download EOBs all in one place.

GRAVIECare™

A better experience with experts in your corner

Every member gets Gravie Care, which includes support from a dedicated team of experts available to help you navigate the complexities of health benefits and make the most of your plan year-round.

Need help understanding your coverage options? Finding a new doctor or specialist? Reading claims & EOBs? **Gravie Care has you covered.** Once you've enrolled, access your plan resources at member.gravie.com.

Connect with Gravie Care

Call us at 855.451.8365 or send a secure message at member.gravie.com/contact

GRAVIE | Teladoc HEALTH

Gravie health plan members have access to **virtual care — including general medical, dermatology, and mental health —** through Teladoc Health, the world leader in whole-person virtual care.

For many Gravie health plan members, these services are included at no additional cost. Check your benefits summary for more information.

General medical

24/7 access to virtual care for a broad range of everyday health issues. With access to board-certified doctors anytime, anywhere, you can avoid unnecessary trips to the doctor's office and costly visits to the ER. Schedule an appointment or choose to talk to a provider right away.

Treatment for a wide range of everyday conditions:

- Flu
- Sinus problems
- Upper respiratory infection
- Pink eye
- Bronchitis
- Nasal congestion
- Sore throat
- Seasonal allergies
- Cold
- Arthritis
- Rash/poison ivy
- And more

How it works

Initiate
Initiate contact through Teladoc's app, website or by phone

Request
Request an immediate visit or schedule a visit at a preferred time

Visit
Visit with the physician via phone or video

Resolve
Physician posts a visit summary to your file and sends RX to your pharmacy if necessary

www.gravie.com

Dermatology

Convenient access to virtual care for a wide range of acute and ongoing skin conditions, including acne, psoriasis, skin infection, rosacea, and more — without the wait. Dermatology through Teladoc Health makes skin care easy.

2 days
to diagnosis versus 32.3 days (avg. wait time in major metropolitan areas)

Approved medication
can be prescribed right through the app or web

How it works

Initiate
Member provides basic information about skin issue through web or mobile app

Upload images
Member uploads a minimum of 3 pictures of the skin issue for the dermatologist to review

View online results
Within 2 business days, the licensed dermatologist responds through the online message center with a diagnosis, treatment, or prescription if necessary

Follow up
Member follows up with the doctor through the message center within 7 days of the initial visit

Mental health

Convenient access to virtual care 7 days a week for a variety of mental health conditions, without the obstacles of conventional in-office treatment. Speak with board-certified psychiatrists, and licensed psychologists and therapists by phone, video, or in-app messaging, from wherever you feel most comfortable.

Common conditions treated:

- Anxiety
- Depression
- Post-traumatic stress disorder (PTSD)
- Obsessive-compulsive disorder (OCD)
- Grief
- Eating disorders
- Stress
- Trauma
- Attention deficit hyperactivity disorder (ADHD)
- And more

How it works

Initiate

Provide basic information, including eligibility, through Teladoc's website, mobile app, or by phone

Request

Select a preferred mental health provider and schedule a visit.

Consult

Speak with selected provider and build ongoing relationship

Support

Ongoing mental health management support is provided

Get started

Step 1

Activate your Teladoc account

- You can easily activate your Teladoc account by logging in to your Gravie member account at https://member.gravie.com/login.
  (If you have an existing account with Teladoc, create a new account with a different email address.)
- Select "**Get Started**" and fill out the information, then select "**Gravie**" as your health plan

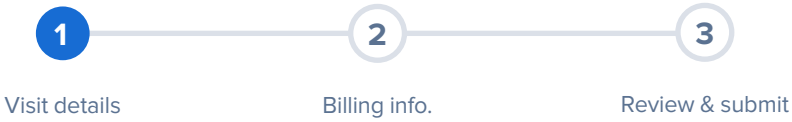
Step 2

Select visit type (General Medical, Dermatology, or Mental Health) and choose a provider

Step 3

Request a visit

- Provide visit details
- If applicable, confirm billing information and pay out-of-pocket costs
- Review and submit request



Step 4

Receive care

- Download the Teladoc Health mobile app at https://www.teladoc.com/mobile/ to access Teladoc on the go.

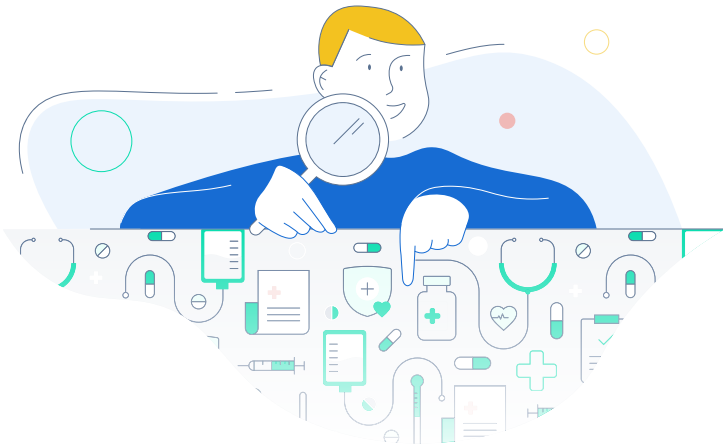
Have questions?

Gravie Care™ has you covered. Give us a call at 855.451.8365 or send a secure message to member.gravie.com/contact

GRAVIE

Preventive Care 101

One of the best ways to stay healthy and save on healthcare costs is to take advantage of the preventive care services that are available to you at no additional charge. With Gravie, you have access to over 80 preventive care services, including annual wellness exams, select health screenings, vaccinations, select counseling services, supplements, preventive care prescriptions, medical devices, and more!



No-cost preventive care services you have access to include:

General Health

- Annual physical exam
- Blood pressure and cholesterol screenings
- Depression screening
- Diabetes screening
- Fall prevention for adults 65 years and over, living in a community setting
- Healthy diet counseling
- Osteoporosis screening
- Sexually transmitted infection (STI) screening and prevention counseling
- Routine eye examination limited to one exam per covered person per calendar year.

Women's Care

- Annual well-woman exam
- Contraception
- Sexually transmitted infection (STI) screening and prevention counseling

Vaccinations

- Diphtheria
- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus (HPV)
- Influenza (flu shot)
- Measles
- Meningococcal
- Mumps
- Pertussis
- Pneumococcal
- Rubella
- Tetanus
- Varicella (Chickenpox)

Pregnancy Care

- Anemia screening
- Breastfeeding support and counseling
- Folic acid supplements
- Preeclampsia prevention and screening
- Sexually transmitted infection (STI) screening and prevention counseling
- Urinary tract or other infection screening

Cancer Prevention

- Breast cancer screening
- Colorectal cancer screening
- Cervical cancer screening
- Lung cancer screening
- Skin cancer prevention counseling

Children's Care

- Autism screening
- Behavioral assessments
- Blood pressure screening
- Healthy diet and obesity counseling
- Hearing and vision screenings
- Immunization vaccinations
- Lead screening
- Phenylketonuria (PKU) screening for newborns
- Well-baby and well-child exams

Mental Health and Drug Abuse

- Alcohol misuse screening and counseling
- Depression screening
- Tobacco use screening and counseling

Expanded Preventive Care

All of Gravie's plans have access to an expanded list of preventive care services, including:

- Angiotensin Converting Enzyme (ACE) inhibitors for those with congestive heart failure, diabetes, and/or coronary artery disease
- Anti-resorptive therapy for those with osteoporosis and/or osteopenia
- Beta-blockers for those with congestive heart failure and/or coronary artery disease
- Blood pressure monitor for those with hypertension
- Inhaled corticosteroids for those with asthma
- Insulin and other glucose lowering agents for those with diabetes
- Retinopathy screening for those with diabetes
- Peak flow meter for those with asthma
- Glucometer for those with diabetes
- Hemoglobin A1c testing for those with diabetes
- International Normalized Ratio (INR) testing for those with liver disease and/or bleeding disorders
- Low-density Lipoprotein (LDL) testing for those with heart disease
- Selective Serotonin Reuptake Inhibitors (SSRIs) for those with depression

For a complete list of all preventive care included in your plan, please reference the Summary Plan Description (SPD) found in your Gravie Member Account.

GRAVIE | FITON

With more than **10+ million** registered users and **3+ million** monthly active users, **FitOn is one of the world's largest health and fitness platforms**. And now, FitOn is included with Gravie health plans!

Gravie health plan members get unlimited access to FitOn's library of 30,000+ virtual classes including cardio, HIIT, yoga, pilates, meditation, dance, barre, and more — all available to Gravie health plan members at no additional cost.

Fitness is more accessible than ever before with FitOn, an industry-leading fitness app that not only brings workouts to you wherever and whenever you choose, but also offers nutrition guides, meal plans, and fitness courses and challenges.

You can even work out with some of your favorite celebrities and fitness brands including Halle Berry, Jonathan Van Ness, Orangetheory Fitness®, Zumba®, and more!

FitOn features:

- 30,000+ live and on-demand virtual fitness and wellbeing classes
- Nutrition recipes and meal plans
- Courses and challenges
- Ability to invite and work out with friends and co-workers

www.gravie.com

Get started

1. Go to peerfit.com/register to register and select **'I have an employer sponsor'**.
2. Enter the email address you would like to use and click **'Send verification code'**.
3. Check your email for your verification code and enter it in the space provided. Click **'Verify code'**.
4. Once verified, **create your password**.
5. Enter your **birthday, first name, zip code and last name. This information must match your employer's records**.
6. Click **'Create'**.
7. Subscribe to FitOn under Digital Subscriptions or at peerfit.com/streaming.
8. After creating your Peerfit account, you can login directly at https://fitonapp.com/ or via the FitOn mobile app using your Peerfit account email.
9. Begin using FitOn!
    - Browse live and on-demand classes, which can be filtered by duration, target area, and intensity
    - Select a multi-week fitness program for consistent support
    - Participate in FitOn fitness challenges for extra motivation
    - Check out FitOn's celebrity workouts
    - Plan meals with recipes, programs, and nutrition expert videos

Have questions?

Contact Peerfit's Client Services team at support@peerfit.com

FitOn + Peerfit is available to Gravie health plan members 18 years of age and over.

GRAVIE

GRAVIE Pay™

When it comes to big purchases, today's consumers expect flexible payment options.

Why should healthcare expenses be any different?

Introducing Gravie Pay

If you have a medical expense, Gravie Pay allows you to split the bill into predictable monthly payments. **No interest, no fees, and no hassle.** Gravie Pay is powered by Paytient, a company that specializes in helping employees pay for care. Paytient is the lender behind Gravie Pay.

How does it work?

Gravie Pay is a virtual card. When paying a bill, either online or over the phone, simply provide your Gravie Pay card information the same way you would any debit or credit card. The provider or pharmacy is paid in full, and you set up repayment through easy payroll deductions, bank account withdrawals, or credit card payments.

Gravie Pay can be used to cover any out-of-pocket medical expense for yourself or dependents enrolled in your Gravie health plan. Merchant codes are used to verify that expenses are healthcare related.

How do I sign up?

Once you're enrolled in a Gravie health plan, activate Gravie Pay by completing a short enrollment process at member.gravie.com. You'll get immediate access to your virtual card, and can start using it as soon as your coverage begins. Easily view transactions and manage your payments at any time from your Gravie account.

What financial considerations should I be aware of?

Your spending limit is equal to the individual out-of-pocket maximum (OOPM) of your Gravie health plan. There are no fees and no interest. Your credit is never checked, impacted, or reported. Your financial health is important to us. When enrolling in Gravie Pay, you may be subject to a couple questions that will assess your ability to repay.

What happens if I miss or can't make a payment?

If you need more time to pay, you can increase the repayment duration to up to 12 months. You can also change your payment method at any time. Gravie Pay is meant to provide you with flexibility.

Still have questions?

Gravie Care™ can help! Call 855.451.8365 or send a secure message at member.gravie.com/contact

GRAVIE | sword

As a Gravie health plan member, you have access to **industry-leading virtual treatment for back, joint, and muscle pain through Sword** at no additional cost.

Combining personalized care from licensed physical therapists with innovative, sensor-based technology, Sword makes it easy to access physical therapy wherever and whenever it's convenient for you.

Sword's clinically validated treatment program **works for all major back, joint and muscle issues, at any point in your journey**: prevention, acute conditions, chronic pain, and post-surgical recovery.

Joints covered include:

Why Sword?

Superior program quality

Receive care from a Doctor of Physical Therapy 100% of the time.

Easy-to-use technology

Receive a tablet and sensors ready to use at home.

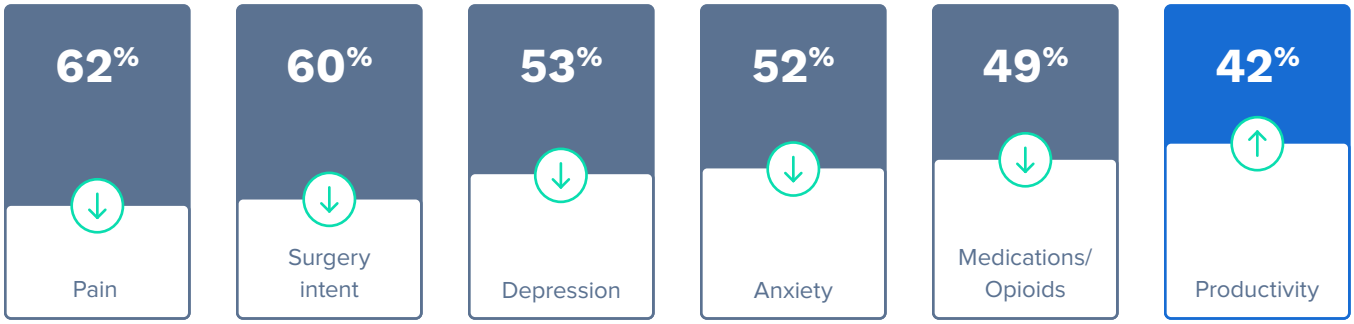
Convenient access to care

Unlike traditional physical therapy, access treatment anytime, anywhere.

www.gravie.com

Digital Physical Therapy changes lives

On average, Sword patients experience less pain, avoid surgery, reduce medication use, reduce depression and anxiety, and improve productivity.



Whether you are looking to **resolve pain you're currently experiencing, or for tools and resources to prevent future pain and live a healthier lifestyle**, Sword has solutions for you.

You can select and access the following resources depending on your needs:

1

Digital Physical Therapy

Remote care offering

Best-in-class care for acute, chronic, and pre- and post-surgical major back, joint, and muscle issues

2

The Academy

Primary prevention

Form healthy habits by developing the skills and techniques needed to avoid major back, joint, and muscle injuries

3

Sword On-Call

On-demand help

Instant, on-demand access to a physical health specialist to guide you when care is needed

Get started

Create your Sword account

You can easily activate your Sword account by logging in to your Gravie member account at https://member.gravie.com/login or through the Gravie mobile app.

Digital Physical Therapy

Remote care offering

If you need help recovering from pain, an injury, or a recent surgery, enroll in digital physical therapy through Sword.

Once enrolled, you're ready to begin your journey to a pain-free life.

Enrollment process for Digital Physical Therapy (PT)

Enroll → Receive digital therapy kit → Video call with Sword PT* → Exercise sessions → **Ongoing PT support**

*In the first PT session, you will be asked to turn on the video to assess your posture and movement, so be prepared.

How it works

- Your dedicated physical therapist designs a personalized exercise program.
- Sword will ship you a tablet and motion sensors to guide you and provide real-time feedback.
- Complete your exercise sessions wherever and whenever it is convenient for you.
- Your physical therapist is there to support you virtually and is available to you at any time.

The Academy (prevention tools) and Sword On-Call (on-demand help)

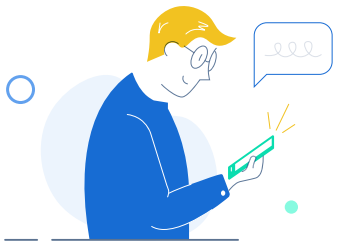
(Enrollment not required)

If a full digital physical therapy program is more care than you need, you could benefit from on-demand access to a clinical pain specialist and premium educational content to help prevent future pain and live a healthier lifestyle, by downloading the Sword mobile app.

The Academy

Primary prevention

Form healthy habits to help prevent and manage back, joint and muscle pain by developing skills and techniques through app-based exercise videos and articles, with this program based on clinical research and guidance from doctors of physical therapy.



Sword On-Call

On-demand help

Instant on-demand access to clinically trained Doctors of Physical Therapy via text message, to ask questions and receive instant responses for back, joint and muscle concerns (8:00 a.m. - 10:00 p.m. ET, 7 days/week).

Sword is available to Gravie health plan members 13 years of age and over.

Have questions?

Gravie Care™ has you covered. Give us a call at 855.451.8365 or send a secure message to member.gravie.com/contact

GRAVIE

Magellan's Value Max Specialty Program

The Value Max Specialty program is designed for members who have been prescribed high-cost specialty medications.

Gravie partners with Magellan to help relieve the financial pressure often associated with specialty drugs by locating the highest copay assistance available for eligible medications. Magellan has identified the most common high-cost drugs, and connects members with copay assistance programs to help them access lower monthly copays.

To access the Value Max Specialty program, members must fill their eligible prescriptions through Magellan Rx Pharmacy's mail-order service.

How does Value Max work?

Comprehensive drug list

Magellan's comprehensive drug list includes the top 50 specialty medications that typically account for 95% of specialty claims costs.

Copay assistance program

The member receives a discounted copay, typically $0 to $5. Actual member copay amounts will vary based on the specific drug and manufacturer discount program.

Member assistance dollars

The program helps to identify member assistance dollars paid by the drug manufacturer and subtracts that cost from the member's deductible and/or out-of-pocket maximum.

Home delivery

With Magellan Rx Pharmacy's home delivery service, it's easy for members to quickly receive their specialty medications while also getting access to additional support to help them stay on track.

What is the Value Max Specialty Program process?

Step 1

The member's doctor will send a prescription to Magellan's Specialty Pharmacy.

Specialty medications must be filled through Magellan's Specialty Pharmacy in order to qualify.

Step 2

A pharmacy representative will contact the member to help them enroll in the qualifying program.

Magellan is typically able to enroll on the member's behalf. However, some manufacturers require the member to self-enroll. This process requires very limited information, usually just the member's name and date of birth.

Step 3

At-home prescription delivery is then coordinated to arrive when and where the member specifies.

Refills will be applied to the manufacturer discount program automatically; the member will not need to provide additional information or re-enroll.

Frequently asked questions

What is a specialty medication?

Specialty medications are used to treat patients with complex and/or rare diseases. They have specific dosage, storage, handling and administration requirements, and they require an elevated level of patient care and monitoring services.

How does a member enroll in the program?

Members prescribed a medication on the Value Max prescription drug list will be automatically enrolled into the Value Max program. Magellan Specialty Pharmacy will reach out directly to the member to help enroll them in various manufacturer savings programs. Certain programs may require the member to self-enroll; in those cases, Magellan will assist the member by reaching out to the member to explain specific requirements.

What if a member wishes to opt out of the program?

A member may opt out from the Value Max program at any time by reaching out to Gravie Care™. Employers and brokers may also request to opt out of the Value Max program on behalf of members by contacting their Gravie Account Manager.

What happens when a member hits the manufacturer discount program maximum?

In the rare instance where a member meets the manufacturer discount program maximum, Value Max will be deactivated and the claim will be applied towards the patient's benefit. For example, a member on a Gravie Comfort™ plan would expect a $0 copay for the specialty prescription, assuming they have already satisfied their out-of-pocket maximum. If the member's out- of-pocket maximum has not been satisfied, the member's responsibility would be a 100% copay until the limit is met.

GRAVIE

Home Delivery by Magellan Rx Pharmacy

Save time and money with a 90-day supply of your medications by mail

Gravie partners with Magellan Rx Management to provide pharmacy benefits through your health plan. If you take maintenance medications for long-term conditions like arthritis, asthma, diabetes, high blood pressure or high cholesterol, you could save with home delivery through Magellan Rx Pharmacy.

How to get started

Getting started with home delivery is easy! First, ask your doctor to write two prescriptions:

1. 30-day supply to fill at your local pharmacy
2. 90-day supply plus refills to fill by mail

Next, you may either ask your doctor to e-prescribe to Magellan Rx Pharmacy, LLC (Mail-ORL) or fax your prescription to 888-282-1349.

- Faxed prescriptions may only be sent by a doctor's office and must include patient information and diagnosis.
- For prompt delivery, please provide your payment information by mailing in your completed home delivery order form or by calling **800-424-8274**.

Mail your 90-day prescription and completed order form with payment to Magellan Rx Pharmacy, P.O. Box 620968, Orlando, FL 32862.

> Home delivery order forms are available at www.magellanrx.com/member/forms

Save Money

Depending on your plan design, you may be able to get a 90-day supply of your medication for less money than three separate fills. And standard shipping is free!

Save Time

Easily refill your medication one time every three months either online or by phone. That means no more drive time or waiting at the pharmacy!

Peace of Mind

Your medication is mailed to you, quickly and securely. Registered pharmacists check all orders and are available to help 24 hours a day, 7 days a week.

When should I use a retail pharmacy?

You should use your local retail pharmacy for the first 30-day prescription of a maintenance medication you get from your doctor as well as prescriptions received for an acute condition, like an infection.

When will I receive my medication?

Your order should arrive 7-10 days after Magellan receives your prescription. They may need to contact your doctor for more info. To avoid delays, be sure to fill out all forms completely and include payment if you know the amount due. Orders with multiple prescriptions may be shipped separately.

Can I set up my prescription to refill automatically?

Yes. You can set up an auto refill to receive eligible home delivery refills automatically. To enroll, call 800-424-8274.

How much are the shipping charges?

Standard shipping is always free. You can choose expedited shipping for an additional charge if you want to receive your medication sooner. Please note that expedited shipping only reduces the transit time and does not impact prescription processing time.

What happens if I don't receive my order?

Making sure you have the medication you need is Magellan's top priority. If you don't receive your order within 10 days, please call 800-424-8274.

Do prescriptions expire?

Most prescriptions, including refills, expire within six months to one year from the day they are written. If this happens you'll need a new prescription from your doctor, even if you have refills remaining.

How are controlled substances handled?

A controlled substance, such as a narcotic, has strict guidelines and may be handled differently than a non-controlled medication. We adhere to federal and state laws in the dispensing of all medications and will contact you if additional information is needed to process a controlled substance prescription.

For questions about your pharmacy benefits plan, call the Member Services number on your member ID card.

For home delivery questions, call 800-424-8274. Representatives can answer questions, check the status of an order, or place a refill order. Pharmacists are also available to help 24 hours a day, 7 days a week.

DELTA DENTAL®

Delta Dental of Iowa

Employee Summary of Covered Services and Benefits

Lewis Central Community School District

Deductibles, Maximums & Eligibility	Delta Dental PPO℠	Delta Dental Premier® / Non Par
- Individual Deductible	$25	$50
- Family Deductible	$50	$100
- Deductible applies to Check-Ups and Teeth Cleaning?	No	No
- Benefit Period Maximum	$1,250	$1,250
- Eligible children through age	25	25
- Full-time (unmarried) students eligible through age	99	99
- Does Individual Deductible apply to Orthodontics?	No	No
- Orthodontic lifetime maximum	$1,000	$1,000
- Orthodontics: Eligible children through age	18	18
- Orthodontics: Full-time students eligible through age	18	18
- Adult Orthodontics	No	No
Benefits		
Check-Ups and Teeth Cleaning (Diagnostic and Preventive Services)	10%	20%
- Dental Cleaning	*2 in a benefit period aggregate with perio maintenance therapy*	
- Oral Evaluations	*2 in a benefit period*	
- Fluoride Applications	*1 in a benefit period through age 18*	
- X-Rays	*Bitewings - 1 every 12 months; Full mouth - 1 every 5 years*	
- Sealant Applications	*1 in a lifetime per permanent 1st and 2nd molars through age 14*	
- Space Maintainers	*Through age 14*	
- Periodontal Maintenance Therapy	*2 in a benefit period aggregate with dental cleaning*	
Cavity Repair and Tooth Extractions (Routine and Restorative Services)	20%	20%
- Emergency Treatment		
- General Anesthesia/Sedation		
- Restoration of Decayed or Fractured Teeth		
- Limited Occlusal Adjustments		
- Routine Oral Surgery		
- Posterior Composites w/ Alternate Processing		
Root Canals (Endodontic Services)	20%	20%
- Apicoectomy		
- Direct Pulp Cap		
- Pulpotomy		
- Retrograde Fillings		
- Root Canal Therapy		
Gum and Bone Diseases (Periodontal Services)	20%	20%
- Conservative Procedures (Non-surgical)	*1 every 24 months per quadrant*	
- Complex Procedures (Surgical)	*1 every 36 months per quadrant*	
High Cost Restorations (Cast Restorations)	50%	50%
- Cast Restorations		
- Crowns	*1 every 5 years*	
- Inlays	*1 every 5 years*	
- Onlays	*1 every 5 years*	
- Post and Cores		
- Recementing Crowns/Inlays/Onlays	20%	20%
Dentures and Bridges (Prosthetic Services)	50%	50%
- Bridges	*1 every 5 years*	
- Dentures	*1 every 5 years*	
- Repairs and Adjustments	20%	20%
- Recementing of Bridges	20%	20%
- Implants Not Covered		
Straighter Teeth (Orthodontics)	50%	50%
Additional Options		
-Annual Maximum Carryover - To Go℠	*Included*	*Included*

This dental plan includes the Annual Maximum Carryover – To Go℠ for carryover of unused Benefit Period Maximums to the next benefit contract year. Please refer to your dental benefits document for details.

The percentage shown is the coinsurance amount that is the responsibility of the Covered Person.

This is a general description of coverage. It is not a statement of your contract. Actual coverage is subject to terms and conditions specified in the benefits document itself and enrollment regulations in force when the benefits become effective. Certain exclusions and limitations apply. Please refer to your dental benefits document for details.

Plan Year 2023

DELTA DENTAL®

To Go℠

Increase Your Annual Benefit Maximum

To Go allows you to carry over any unused annual maximums from one year to the next. This benefit offers more flexibility and helps you plan for more extensive and costly dental treatments in subsequent years.

How To Go Works

For example, if your plan has an annual maximum of $1,250, here is how you can use To Go.

Year 1		Year 2		Year 3	
Annual Benefit Maximum	$1,250	Annual Benefit Maximum	$1,250	Annual Benefit Maximum	$1,250
Eligible Benefit Used	$500	To Go Benefit from Year 1	$750	To Go Benefit from Year 2	$1,250
Unused Annual Benefit Maximum	$750	Year 2 Annual Benefit Maximum	$2,000	Year 3 Annual Benefit Maximum	$2,500
To Go – Annual Maximum Carryover (for use in year 2)	$750	Eligible Benefit Used	$500	Eligible Benefit Used	$1,500
		Unused Annual Benefit Maximum	$1,500	Unused Annual Benefit Maximum	$1,000
		To Go – Annual Maximum Carryover (for use in year 3)	$1,250*	To Go – Annual Maximum Carryover (for use in year 4)	$1,000*

Questions?

If you have any questions about your dental benefits, visit the Delta Dental website at deltadentalia.com and log into the Member Connection or you can call customer service at 800-544-0718.

To Go Guidelines:

1. You must be covered under the plan for the full benefit plan year, with coverage for major services, and not subject to any benefit waiting periods for these services.
2. You must have submitted at least one claim during the benefit plan year that would apply to your annual maximum.
3. The carryover amount may not exceed the amount of the regular annual maximum and the total combined annual maximum may not exceed twice the regular annual maximum.

* The To Go – Annual Maximum Carryover amount cannot exceed the annual benefit maximum.

DeltaVision®

Set Your Sights On Discounts

DELTAVISION DISCOUNT PLAN

VISION CARE MATTERS

Eye care goes beyond vision. Your eyes say a lot about you — from your emotions to your overall health. Being proactive about protecting your eyes makes a clear, positive impact. Regular eye exams not only correct vision problems, but they also can reveal early warning signs of more serious health conditions such as hypertension, cardiovascular disease and diabetes.[1] So put yourself on a path to better health by scheduling eye exams annually.

KEEP ON SAVING

You can use your DeltaVision discount as often as you like all year long on nearly all your vision care purchases at participating providers.

[1] www.cdc.gov/features/healthyvision/

LEARN MORE

To find providers near you or for more information about vision wellness, visit **deltadentalia.com/deltavision**.

EyeMed | Independent Provider Network + LensCrafters | Pearle Vision | Optical | Sears Optical | JCPenney | optical

LOCATE A PROVIDER

You love choices — and so do we. That's why our network has thousands of independent doctors & retail providers.

SCHEDULE AN APPOINTMENT

Call ahead or stop by one of the many providers that offer walk-ins. Most also have evening and weekend hours to fit any schedule.

SHOW YOUR ID CARD

When you arrive, let the provider know you have a discount through DeltaVision.

Please note your discount cannot be combined with any other discounts, coupons or promotional offers.

DeltaVision®

EyeMed Member/Patient Services:
1.866.246.9041
ACCESS DISCOUNT PLAN
DELTAVISION
Discount plan# 9231093

Signature: _____

This is not insurance.
Dependents are eligible.

Please detach carefully at perforation and keep card in your wallet.

DeltaVision® DISCOUNT PLAN

Access network

Vision Care Services	Member Cost
Exam and dilation as necessary	$5 off routine exam $5 off contact lens exam
Complete pair of glasses purchase*: Frame, lenses and lens options must be purchased in the same transaction to receive full discount.	
Standard plastic lenses: Single Vision Bifocal Trifocal	 $50 $70 $105
Frames	35% off retail price
Lens options: UV treatment Tint (solid and gradient) Standard plastic scratch coating Standard polycarbonate Standard progressive lens (Add-on to bifocal) Stardard anti-reflective coating Other add-ons and services	 $15 $15 $15 $40 $65 $45 20% off retail price
Contact lens materials: (Discount applied to materials only) Disposable Conventional	 0% off retail price 15% off retail price
Laser vision correction:** LASIK or PRK	15% off retail price or 5% off promotional price
Frequency: Examination Frame Lenses Contact lenses	 Unlimited Unlimited Unlimited Unlimited

THIS IS NOT INSURANCE

*Items purchased separately will be discounted 20% off of the retail price.

**Since LASIK and PRK vision corrections are elective procedures, performed by specially trained providers, this discount may not always be available from a provider in your location. For a location near you and the discount authorization, please call 1.877.5LASER6.

Member will receive a 20% discount on those items purchased at participating providers that are not specifically covered by this discount. The 20% discount does not apply to EyeMed providers' professional services or contact lenses. Retail prices may vary by location. All discounts cannot be combined with any other discounts or promotional offers.

This discount design is offered with the EyeMed Access panel of providers.

DeltaVision®

DELTA DENTAL

EyeMed Member/ Patient Services:
Visit eyemed.com or call the number on the front of this card.

EyeMed Doctors/ Providers Only:
Visit eyemed.com to receive plan information or authorization online or call 1.800.521.3605.

Private Practitioners · LensCrafters · Pearle Vision · sears optical · OPTICAL · optical

LIMITATIONS/EXCLUSIONS:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Corrective eyewear required by an employer as a condition of employment and safety eyewear unless specifically covered under plan
- Services provided as a result of any Workers' Compensation law
- Discount is not available on those frames where the manufacturer prohibits a discount

Visit deltadentalia.com/deltavision to learn more or locate a provider near you.

1507-F10010

A LOOK AT YOUR VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM LEWIS CENTRAL COMMUNITY SCHOOL DISTRICT AND VSP.

VSP® Vision care for life

Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

It's easy to find a nearby in-network doctor. Maximize your coverage with bonus offers and savings that are exclusive to Premier Program locations—including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

PREMIER PROGRAM

Visionworks

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

GET YOUR PERFECT PAIR

EXTRA $20 TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST EYEWEAR

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

+

UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

Enroll today.

Contact us: **800.877.7195** or **vsp.com**

YOUR VSP VISION BENEFITS SUMMARY

Lewis Central Community School District and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice

EFFECTIVE DATE:
07/01/2022

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every 12 months
PRESCRIPTION GLASSES		$25	See frame and lenses
FRAME	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Walmart®/Sams Club®/Costco® frame allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
PRIMARY EYECARE	• As a VSP member, you can visit your VSP doctor for medical and urgent eyecare. Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Ask your VSP doctor for details.	$20	As needed
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Log in to vsp.com to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Log in to **vsp.com** to find an in-network provider based on your plan type.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

It's easy to create an account on vsp.com.

vsp Vision Care

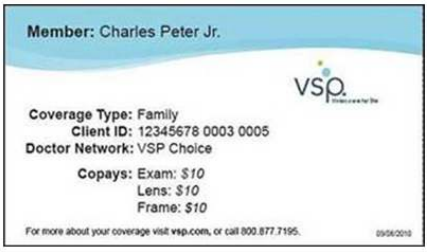
Just follow these steps:

Get Started Today!

1. Visit **vsp.com**
2. Click on CREATE AN ACCOUNT at the top of the page
3. Enter the member's SSN or Member ID Number
4. Enter the member's first and last name
5. Enter the member's date of birth
6. Click CONTINUE
7. Follow the steps to create a user name and password

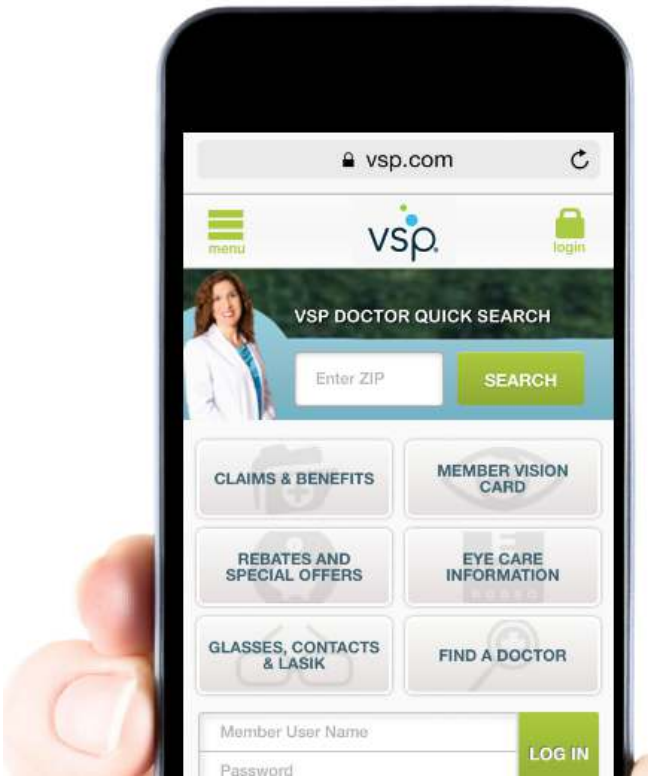
Once you create an account, you can review your benefit information, access personalized eligibility and plan coverage details, and print a Member Vision Card.

Please Note: VSP does not create new ID cards. You can obtain a Print-On-Demand ID card through your VSP account.



vsp.com at your fingertips

- **Find a doctor** by name or location, and get directions to your appointment.
- Access your **Member Vision Card** and personal benefit information.
- View **Exclusive Member Extras**, like rebates, special offers, and promotions.
- Get **eye care information** on a variety of topics to maintain optimal eye health.



FLEXIBLE SPENDING ACCOUNTS (FSA) iSolved

Plan Overview

Pre-Tax Premium Benefits
This plan allows you to fund several of your premium contributions with pre-tax dollars and to fund either a Health Care Reimbursement Account and/or Dependent Care Reimbursement Account. Your contributions are deducted from your gross wages before FICA, Federal and State taxes are deducted. You save money because you are taxed at a reduced income level. Your taxes are calculated after your premiums and reimbursement account monies are deducted from your gross wages.

Health Care Reimbursement Accounts
This plan allows you to defer pre-tax dollars into a Health Care Reimbursement Account to pay for certain IRS-approved medical care expenses not covered by your insurance plan with pre-tax dollars. Some examples include:

- Deductible, coinsurance and copayments
- Over the counter medications – with prescription
- Dental services and orthodontia
- Vision services, including contact lenses, contact lens solution, eye exams and eyeglasses
- Hearing services, including hearing aids and batteries

Health Care Maximum: $3,050

Dependent Care Reimbursement Accounts
This plan allows you to defer pre-tax dollars into a Dependent Care Reimbursement Account. You may request reimbursement as you incur expenses to provide day care for qualified dependents: children under age 13, or an older disabled dependent child, or a disabled adult.

Dependent Care Maximums: $5,000 if married filing jointly or head of household; $2,500 if married filing single.

Plan Provisions

Please Note: Your election in the Lewis Central CSD Section 125 Flexible Benefit Plan is irrevocable for the entire plan year (July 1st through June 30th) without a qualifying change in status (i.e. birth, adoption, divorce, job status change, etc.). Please be advised that any unused FSA monies over your allowed rollover amount will be forfeited back to the Plan at the end of the plan year.

Rollover Feature
Participants in a Health Care Reimbursement Account are allowed to rollover up to $610 per year. The maximum election will continue to be $3,050; rollover funds will be added to the maximum. If you are going to enroll in the high deductible health plan for the first time and you have funds to rollover, you must designate and use the rollover amount for limited purpose only (dental and vision) to be eligible to open a health savings account.

- These funds will rollover into the new plan year once the current plan year's runout period has ended.

Claim Submission
Claims may be filed by mailing, faxing, or online. Please be aware that your plan has a run out period, after the end of the plan, where you may still file claims. Remember that the expense, however, must have been incurred during the plan year.

FSA Debit Card
All enrollees receive an FSA debit card to pay for eligible expenses at the time of claim. You automatically receive 1 card and may request 1 additional card for a dependent. Any additional cards or replacement cards are subject to a fee. Your FSA debit card comes fully loaded with your annual election amount on the effective date. Your debit card will be reloaded each year IF you re-enroll in the FSA. Funds expire annually but your debit card is valid until the expiration date on the card.

Claim Processing
Claims are processed on a daily basis. Reimbursements may be automatically deposited into your checking account.

isolved Benefit Services

Flexible Spending Accounts.

Real Savings. Real Simple.

Using a Flexible Spending Account (FSA) is a great way to stretch your benefit dollars. You use pre-tax dollars in your FSA to reimburse yourself for eligible out-of-pocket medical and dependent care expenses. That means you can enjoy tax savings with the convenience of a prepaid benefits card. And that makes real sense.

What is an FSA?

With an FSA, you elect to have your annual contribution (up to the annual limit set by the IRS) deducted from your paycheck each pay period in equal installments throughout the year. The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified expenses and services. Please check with your employer to see what plans are offered.

A Health FSA allows reimbursement of qualifying out-of-pocket medical expenses.

A Dependent Care FSA allows reimbursement of dependent care expenses, such as day care, incurred by eligible dependents.

A Limited Purpose Health FSA is compatible with a Health Savings Account (HSA). A limited FSA only allows reimbursement for preventive care, vision and dental expenses, keeping the employee eligible to contribute to an HSA.

With all FSA account types, you'll receive access to a secure, easy-to-use web portal where you can track your account balance, view your investment accounts and submit requests for reimbursements.

In addition, your plan might offer a convenient prepaid benefits card to make it easy to pay for eligible services and products. When you use the card, payments are automatically withdrawn from your account, so there are no out-of-pocket costs and you likely won't have to submit receipts to verify the purchase. Just swipe the card and go. **It's that easy!**

Throughout the year, you'll likely incur expenses for yourself and your family that insurance won't cover. By taking advantage of a health care FSA, you can actually reduce your taxable income and reduce your out-of-pocket expenses when you use your FSA to pay for health care services and products you'd purchase anyway.

isolved

Is an FSA right for me?

An FSA is a great way to pay for expenses with pre-tax dollars. A Health Care FSA could save you money if you or your dependents:

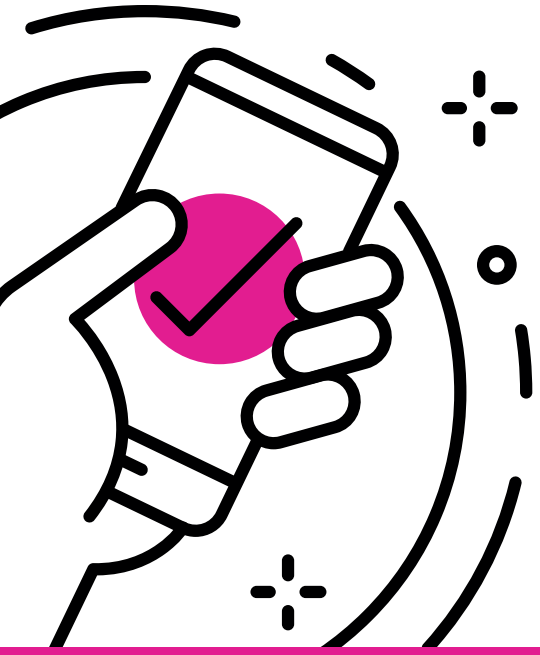
- Have out-of-pocket expenses like **co-pays, coinsurance, or deductibles** for health, prescription, dental or vision plans
- Have a **health condition that requires the purchase of prescription medications** on an ongoing basis
- Wear **glasses or contact lenses** or are planning **LASIK surgery**
- Need **orthodontia care, such as braces,** or have dental expenses not covered by your insurance

A Dependent Care FSA provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. This benefit may make sense if you (and your spouse, if married) are working or in school, and:

- Your **dependent children under age 13 attend day care, after-school care** or **summer day camp**
- You **provide care for a person of any age who you claim as a dependent on your federal income tax return** and who is mentally or physically incapable of caring for himself or herself

An FSA is a great way to pay for expenses with pre-tax dollars.

- Enjoy significant tax savings with pre-tax contributions and tax-free distributions used for qualified plan expenses
- Quickly and easily access funds using the prepaid benefits card at point of sale, or request to have funds directly deposited to your bank account via online or mobile app
- Reduce filing hassles and paperwork by using your prepaid benefits card
- Enjoy secure access to accounts using a convenient Consumer Portal available 24/7/365
- Manage your FSA "on the go" with an easy-to-use mobile app
- File claims easily online (when required) and let the system determine approval based on eligibility and availability of funds
- Stay up to date on balances and action required with automated email alert and convenient portal and mobile home page messages
- Get one-click answers to benefits questions



With the convenience of a mobile device, you can see your available balance anywhere, anytime, as well as file claims and upload receipts.

Plan Ahead

Before you enroll, you must first decide how much you want to contribute to your account(s). You will want to spend some time estimating your anticipated eligible medical and dependent care expenses for the calendar year.

As of **October 31, 2013**, the U.S. Treasury Department modified its Health Flexible Spending Account (FSA) Use-or-Lose rule to allow up to a $570 carryover of Health FSA funds. The carryover option is based solely on your employer's plan design. Not every company allows a carryover. Some employer plans may establish a lower maximum limit than $570, but it must be uniformly applied to all eligible participants. The carryover is applicable only to Health FSAs (not to Dependent Care FSAs). Any unused amount above the carryover limit is subject to forfeiture and cannot be cashed out or transferred to other taxable or nontaxable benefits (e.g., HSAs).

For questions, contact us at: **FSA@isolvedhcm.com** or **800-300-3838**

Transforming employee experience for a better today and a better tomorrow.

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Dependent Care FSA

FAQ's

A Dependent Care FSA provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. It's a great option for employees who have dependent children under the age of 13 who attend day care, after-school care or summer day camp, and/or provide care for a person of any age who is claimed as a dependent on the federal income tax return and who is mentally or physically incapable of caring for himself or herself.

Who is a qualified dependent under the Dependent Care FSA?

- Dependent under the age of 13
- Dependent or spouse of employee who is mentally or physically disabled and whom the employee claims as a dependent on their federal income tax return

Can an adult be a qualified dependent?

Yes, an adult may qualify as a dependent provided that the employee is providing more than half of that individual's support for the year and the dependent lives with the employee.

Do I have to use a day care facility?

No. You can be reimbursed for expenses of an individual providing care for your dependent in your home as long as the expenses are incurred for you and your spouse (if married), to work, look for work or attend school full time.

Does my day care provider have to be licensed?

No. However, you are required to submit their Tax Identification Number or Social Security Number when filing your federal income tax return.

My child attends camp during the summer. Is this eligible?

Generally, no. However, if the camp is a day camp and your dependent attends to allow you and your spouse (if married) to work, look for work or attend school full time, then yes, this would be an eligible expense. Overnight camps are specifically excluded.

Does my day care provider have to be 18?

No, but the individual must claim the money as income on their tax return.

When can I be reimbursed for dependent day care expenses?

Expenses are eligible for reimbursement when they have been incurred, not when you are billed or when you pay for the services.

Example: Your day care provider requires you to pay for the month of September on September 1. You can be reimbursed as the services are incurred, not when you paid for the services. You can submit claims after each week, every week or on October 1.

What support documentation must I file with each Dependent Care claim?

Complete the Dependent Care section of the Request for Reimbursement Form and have your day care provider sign and date. The receipt must include the following information:

- Name and address of provider
- From/through dates of service
- Amount of charge

Can I submit claims for dependent care expenses that are greater than the current balance of my Dependent Care FSA?

Yes. However, you will only receive reimbursement for the amount that you have contributed to your Dependent Care FSA. For example, if you contribute $150 each month to your Dependent Care FSA, then you will only receive $150 in reimbursement each month. The excess amount of expenses will be pended and automatically paid to you as contributions are posted to your account.

What happens if a claim exceeds the amount currently available in my Dependent Care FSA?

The claim will be processed and approved. The amount that is currently available will be disbursed and the remaining portion will be pended until you make another contribution.

isolved Benefit Services

iFlexWDM MOBILE APP

Check account balances, submit claims, and review resources for your Flexible Spending Account (FSA)

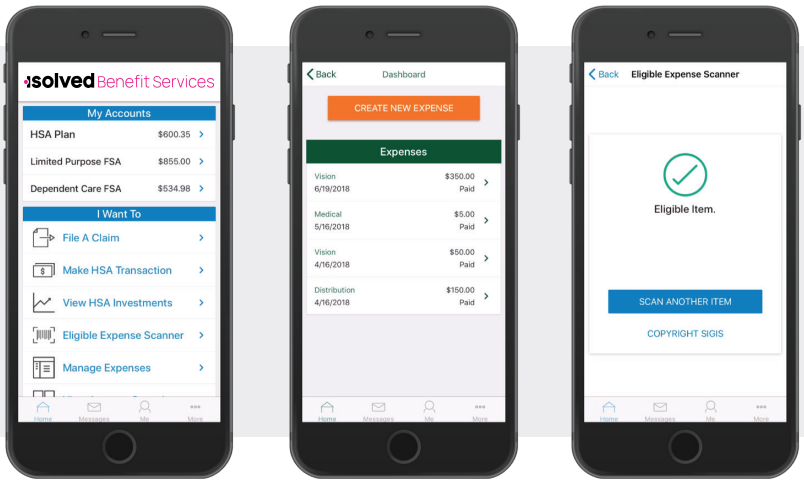
When you enroll in the company-sponsored Flexible Spending Account (FSA), you have a variety of tools and resources available at your fingertips. One of these offerings is the **iFlexWDM** mobile app, which allows you to use your mobile device to check health benefit account balances from anywhere at any time.

Search for **isolved Benefit Services WDM** as soon as you enroll in the FSA and start using your smartphone or tablet to access your account balance. It's easy to see exactly how much money you have available to spend on qualified health or dependent care expenses at the time of purchase. You can also submit claims for reimbursement and upload receipts using the camera on your mobile device.

There is also an option to set up text message alerts for balance updates and other configurable data.

***iFlexWDM** gives you access from anywhere, simplifying the process of making the most out of your FSA funds.*

No sensitive account information is ever stored on your mobile device.



Download on the App Store | GET IT ON Google Play

The iFlexWDM mobile app is available for free on Google Play and the App Store.

As soon as you enroll in the company-sponsored FSA, search for **iSolved Benefit Services WDM** in the app store to start enjoying instant access to your FSA account information, along with a variety of resources, from your mobile device.

Know Your Eligible and Ineligible Expenses

Eligible Expenses

Baby/Child to age 13
- Lactation consultant
- Lead-based paint removal*
- Special formula*
- Tuition: special school/teacher for disability or learning disability
- Well baby/well child care

Dental
- Dental x-rays
- Dentures and bridges
- Exams and teeth cleaning
- Extractions and fillings
- Oral surgery
- Orthodontia
- Periodontal services

Eyes
- Eye exams
- Eyeglasses and contact lenses
- Laser eye surgeries
- Prescription sunglasses
- Radial keratotomy

Hearing
- Hearing aids and batteries
- Hearing exams

Lab Exams/Tests
- Blood tests and Metabolism tests
- Body scans
- Cardiograms
- Laboratory fees
- X-rays

Medications
- Insulin
- OTC drugs
- Prescription drugs

Medical Equipment/Supplies
- Air purification equipment*
- Arches and other orthotic inserts
- Contraceptive devices
- Crutches, walkers, wheel chairs
- Exercise equipment*
- Hospital beds*
- Mattresses*
- Medic alert bracelet or necklace
- Nebulizers
- Orthopedic shoes*
- Oxygen
- Post-mastectomy clothing
- Prosthetics
- Syringes
- Wigs*

Obstetrics
- Doulas*
- Lamaze class
- OB/GYN exams
- OB/GYN prepaid maternity fees (reimbursable after date of birth)
- Pre- and post-natal treatments

Practitioners
- Allergist
- Chiropracter
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Osteopath
- Physician
- Psychiatrist or Psychologist

Therapy
- Alcohol and Drug addiction
- Counseling (must be treating a medical condition)
- Exercise programs*
- Hypnosis*
- Massage*
- Occupational
- Physical
-Smoking cessation programs
- Speech
- Weight loss programs

Medical Procedures/Services
- Acupuncture
- Alcohol and drug/substance abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility enhancement and treatment
- Hair loss treatment*
- Hospital services
- Immunization
- In vitro fertilization
- Personal trainers*
- Physical examination (not employment-related)
- Reconstructive surgery (due to a congenital defect, accident or medical treatment)
- Service animals
- Sterilization/sterilization reversal
- Transplants (including organ donor)
- Transportation*

This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a note of medical necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact isolved Benefit Services.

Over-the-Counter (OTC) Medicines, purchased on or after January 1, 2020, were reinstated with the passage of the CARES Act (COVID-3 Stimulus Bill) for HSAs, FSAs and Archer MSAs (unless your plan excludes OTC items). OTC items can be purchased with funds from eligible accounts without needing a prescription. Additionally, the bill expanded OTC items to include menstrual care products.

Eligible Over-the-Counter Items

Note: Product categories are listed in bold face; common examples of products are listed in regular face.

The following is a high-level list of over-the-counter (OTC) items that are not medicine or drugs and are eligible for purchase with Health Care FSA dollars. You can use your benefits card for these items

Antiseptics, wound cleaners
Alcohol, peroxide, Epsom salt

Baby electrolytes
Pedialyte, Enfalyte

Denture adhesives, repair and cleansers
PoliGrip, Benzodent, Efferdent

Diabetes testing and aids
Insulin, Ascencia, One Touch, Diabetic Tussin, insulin syringes, glucose products

Sunscreen (SPF 15 and over)

Diagnostic products
Thermometers, blood pressure monitors, cholesterol testing

Elastics/athletic treatments
ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts

Eye care
Contact lens care

Family planning
Pregnancy and ovulation kits

First aid dressings and supplies
Band Aid, 3M Nexcare, non-sport tapes

Hearing aid/medical batteries

Incontinence products
Attends, Depend, GoodNites for juvenile incontinence

Feminine hygiene products
Sanitary pads, tampons, panty liners

Ineligible Expenses

Note: This list is not meant to be all-inclusive

The IRS does not allow the following expenses to be reimbursed the FSA, as they are not prescribed by a physician for a specific ailment.

Contact lens or eyeglass insurance

Cosmetic surgery/procedures

Electrolysis

Marriage or career counseling

Swimming lessons

Sunscreen (SPF less than 15 needs RX)

BASIC LIFE / ACCIDENTAL DEATH & DISMEMBERMENT

Madison National

Plan Overview

Basic Benefit Amount
Full-time School Year Hourly Employees: $30,000

Accidental Death Benefit
Amount is the same as the Basic Life amount.

Living Care Benefits
If you have a qualifying medical condition, you may apply for an accelerated benefit to receive a portion of your life insurance once *during your lifetime*. Amount of benefit: 50% of the Life Insurance in force, but not to exceed $50,000.

Conversion
Must apply for conversion within 31 days of termination of policy.

Age Reduction
Benefit reduces to 65% at age 70
Benefit reduces to 50% at age 75
Benefit terminates at retirement

VOLUNTARY TERM LIFE INSURANCE

Madison National

Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself, you may also elect coverage on your dependents in this benefit, you pay the full cost through payroll deductions.

Voluntary Coverage Amounts

Employee may elect up to $300,000

Minimum:	$5,000
Maximum:	$300,000
Multiples of:	$5,000

Spouse may be covered for up to 50% of the employee amount

Minimum:	$2,500
Maximum:	$100,000
Multiples of:	$2,500

Child(ren)

Option 1:	$5,000 Child / $500 Infant
Option 2:	$10,000 Child / $1,000 Infant
Definitions:	Infant – 0 Days to 6 months; Child – 6 months to age 19/23 if full-time student

Accidental Death Benefit

Amount is the same as the Voluntary Coverage Amount

Waiver of Premium

Life insurance continues for totally disabled employees without payment of premium if:

- Disability begins while the employee is insured;
- Disability begins prior to age 60 and terminates at age 70;
- Proof of disability is given to Carrier, prior to the end of the Disability Elimination Period;
- Proof of continued disability is verified periodically, according to the terms of the contract.

Portability

Apply for within 31 days of termination.

Age Reduction

Benefit reduces to 65% at age 70
Benefit reduces to 50% at age 75
Benefit terminates at retirement
*Spouse benefit will terminate at age 70

VOLUNTARY TERM LIFE RATE

Employee and Spouse Age Rates (Life and AD&D)

Age	Rate per $1,000
to age 29	0.085
30 to 34	0.105
35 to 39	0.125
40 to 44	0.155
45 to 49	0.225
50 to 54	0.335
55 to 59	0.585
60 to 64	0.805
65	1.295
66	1.295
67	1.445
68	1.595
69	1.765
70	2.085
71	2.145
72	2.365
73	2.585
74	2.795
75+	3.205

Dependent Child Rates (Life Only)

Option 1 ($5,000 child/ $500 Infant) = $.90 per family per month*
Option 2 ($10,000 child/ $1,000 Infant) = $1.80 per family per month*

*Covers all children and infants meeting age guidelines.

Coverage Election	Coverage Amount	x	Rate	÷	Units	=	Monthly Premium
Employee		x		÷	$1,000	=	
Spouse		x		÷	$1,000	=	
Child	Enter **$0.90** for Option 1, **$1.80** for Option 2 or **$0** to waive.					=	
						Total Monthly Premium	

EXAMPLE: Employee or spouse age 43 elects $30,000 of coverage
$30,000 (coverage amount) x .155 (rate) ÷ 1,000 = $4.65/month

LONG TERM DISABILITY INSURANCE

Madison National

Lewis Central CSD provides full-time school year employees with long term disability income benefits and pays the full cost of this coverage. In the event you become disabled, disability income benefits are provided as a source of income.

Plan Overview	
Benefit Amount	60% of monthly salary
Own Occupation Period	2 years
Elimination Period	Accumulated sick leave plus 15 days
Maximum Benefit Period	Social Security Normal Retirement Age (65)
Maximum Benefit Amount	$6,250
Survivor Benefit	3 months
Zero Day Residual	Zero day residual stipulates that full-time or part-time work in which the employee is performing all of the material duties of his or her regular, or some other occupation, will not interrupt the qualifying (elimination) period, or the period of disability
Pre-Existing Condition Waiting Period	None

Long Term Disability Example for Maximizing Monthly Disability Benefit

Long term disability payments are taxable to the insured to the extent they are paid by the employer. Since the employer pays 100% of the premium for LTD, 100% of the monthly benefit at time of disability is taxable. The following is an option, approved by the IRS, which dramatically increases the benefit at time of disability if you choose to have the employer paid premiums included as taxable income in your W-2.

Example of 100% taxable Benefit - 60%

Employee earning $40,000 per year becomes disabled. The employer pays 100% of the cost of the long term disability insurance. Assume for this example that Social Security has not yet been approved. Employee actually receives only 42% of their pre-disability earnings, even though the benefit is considered to be 60% of salary.

Salary	$3,333.33
Benefit %	0.60
Gross Mo. Benefit	$2,000.00
Less 30% taxes	0.70
Net Mo. Benefit	$1,400.00
Salary replacement %	**0.42**

Example of non-taxable benefit - 60%

Employee earning $40,000 per year becomes disabled. The employer pays 100% of the cost of the long term disability insurance. The employee has chosen to have the amount of the employer paid premiums included as taxable income on his W-2 and he will pay taxes on the annual premium amount. Assume for this example that Social Security has not yet been approved. Employee actually receives 60% of their pre-disability earnings, which is more per year than in the taxable 60% benefit plan.

Salary	$3,333.33
Benefit %	0.60
Gross Mo. Benefit	$2,000.00
Less Taxes	0.00
Net Mo. Benefit	$2,000.00
Salary replacement %	**0.60**
Annual difference in amount of benefit paid:	**$7,200.00**

Your savings

Annual premiums at your current cost:
Employee would pay taxes on the annual premium. Using this technique, the disabled employee would realize additional annual income of:

$3,333/Mo. @ .189/$100 X 12	$75.60
30% tax = annual cost to employee	$22.68
Net annual increase in payments to employee	**$7,177.32**

This equates to over three additional months of income per year. If you earn more than $6,000 per month, there is even greater benefit for you to take advantage of this optional technique to ***safeguard your financial security. The negative impact of having a taxable disability benefit becomes even greater as the level of income increases.***

EFR EMPLOYEE & FAMILY RESOURCES

CORE EAP BENEFIT SUMMARY

Lewis Central Community School District

Maintaining work-life balance is more stressful than it's ever been. An Employee Assistance Plan (EAP) provides a variety of counseling, consultations, resources, and coaching benefits for you and your family members to help with small concerns, big problems, and everything in between. **Your EAP benefits are cost free to you, confidential, and available 24/7/365.** Let us help you get the services and resources you need. Here are some issues and concerns we can help with:

- ✓ Managing Stress
- ✓ Relationship Concerns
- ✓ Personal Growth & Development
- ✓ Coping with Anxiety or Depression
- ✓ Personal Family or Legal Issues
- ✓ Caring for Elderly Family Members
- ✓ Credit Concerns and Reports
- ✓ Identity Theft Resolution
- ✓ Substance Use and Addiction
- ✓ Managing Budgets and Debts
- ✓ Legal Questions & Concerns
- ✓ Tax-Related Questions

SERVICE PROVIDED	PER PERSON	SERVICES PROVIDED ARE CONFIDENTIAL AND AT NO COST TO THE COVERED PERSON
Phone-Based Support	Unlimited	Call us any time you have an issue, concern, or question. Calls are answered 24/7 by masters-level clinicians.
In-person Counseling	**3** Sessions per circumstance, per year	Confidential, in-person assessment and counseling with a licensed mental health therapist near your home or work location. Each member of your family is eligible for counseling services for each separate incident or set of circumstances within a rolling 12-month period. ***incidents involving multiple family members will be assessed based on specific circumstance***
Telephonic Life Coaching	**3** Sessions per year	Confidential, scheduled telephonic sessions with a life coach for matters such as improving time management skills, work-life integration, goal setting, communication skills, and other areas of personal growth. Sessions renew annually.
Telephonic Financial Consultation	**1** session per issue	A 30-minute telephonic consultation for each separate issue with a financial professional with expertise in the area of concern. Access a free financial check-up, financial library, and a large variety of financial tools & calculators at http://efr.clcmembers.com/.
In-Person or Telephonic Legal Consultation	**1** session per issue	A 30-minute telephonic or in-person consultation for each separate issue/concern with a licensed attorney with expertise in the area of need. If the member chooses to retain the attorney for ongoing legal representation, it will be provided at a 25% discount off the attorney's usual rate. Access to more than 5,000 free self-help (& fill-in) legal documents and a variety of other legal information is available at http://efr.clcmembers.com/. *All legal concerns are covered, except employment-related issues, which are specifically excluded.*
Eldercare Resources	As needed	Information, referral resources, and support for those caring for an aging parent or other family member, including connections to local resources for in-home care, alternative living arrangements, legal and financial issues, and more.
Childcare Resources	As needed	Childcare resource referrals where locally available. Referrals are only to state licensed/ certified childcare providers.
Identity Theft Resolution Services	As needed	Services are provided by a highly-trained FCRA certified fraud resolution specialist (or licensed attorney) to assist with restoring identity and good credit.
Additional Benefits & Resources		*Real Life Solutions* (monthly newsletter), benefit orientation webinars, blogs, self-assessments, and other EAP information is available via your HR manager, via our online chat at ***www.efr.org/chat***, or on our website, ***www.efr.org***.

EFR EMPLOYEE & FAMILY RESOURCES

GET CONNECTED:

Call us 24/7 at **800.327.4692**
or visit us at **efr.org**

EFR EMPLOYEE & FAMILY RESOURCES

Understanding Your EAP Benefits

EFR is dedicated to helping people manage life's challenges so they can reach their full potential.

When should I call the EAP?

Call **800-327-4692** whenever you are experiencing one of life's challenges. We are available 24/7/365.

What happens when I call?

A master's level counselor will answer your call and is available to talk with you about your issues, concerns, or struggles.

The counselor will gather demographic information and help you connect with an EAP counselor.

What happens when I see the EAP counselor?

- The master's level EAP counselor will listen to your concerns.
- The counselor will also help you explore other areas of your life to assess for strengths and supports, or factors contributing to your presenting issue or concern.
- The counselor will meet with you up to **3 sessions** to complete a comprehensive assessment of your current circumstances and work with you to establish a plan.

Options for EAP sessions include:

- Assessment completed and remaining sessions are used for brief counseling and problem resolution.
- Assessment completed and a referral is recommended for services that fall outside the scope of EAP services.

Common Questions

Can I use the EAP more than once a year?

- Yes, but each time you use the EAP, the counselor will be assessing your current life circumstances. You will be eligible for a new set of **3 sessions** if your circumstances have changed, or in 12 months, whichever comes first.

What is a new set of circumstances?

- A new development in your life that has changed since your last EAP assessment, such as death of a loved one, a breakup/divorce, or job loss/layoff.

Why can't I use the EAP more often?

- EAP is an assessment, referral, and brief counseling model to help employees manage a wide variety of personal issues, but is not intended to replace therapy, treatment, or ongoing counseling.

Call EFR today!

800-327-4692

Group Voluntary Accident

Accident coverage can help pick up where major medical insurance leaves off and provide lump sum cash payments depending on condition, due to a covered accident, to help cover out of pocket expenses. Cash benefits are paid directly to you.

BENEFITS:

Benefits	Additional Riders Added to Base Policy
• Initial Hospital Confinement • Daily Hospital Confinement • Intensive Care	• Accident Treatment and Urgent Care Rider Ground or Air Ambulance Accident Physician's Treatment X-ray Urgent Care • Dislocation/Fracture Rider • Emergency Room Services Rider

Benefit Enhancements		
Lacerations	Open Abdominal or Thoracic Surgery	Post-Accident Transportation
Burns	Ruptured Spinal Disc Surgery	Broken Tooth
Skin Graft	Appliance	Residence/Vehicle Modification
Brain Injury Diagnosis	Medical Supplies	Pain Management
Paralysis	Medicine	Miscellaneous Outpatient Surgery
Coma with Respiratory Assistance (n/a GA)	Prosthesis	Accident Follow-up Treatment
Eye Surgery	Physical, Occupational, or Speech Therapy	Tendon, Ligament, Rotator Cuff, or Knee Cartilage Surgery
General Anesthesia	Rehabilitation Unit	Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI)
Blood and Plasma	Non-Local Transportation	
	Family Member Lodging	

KEY FEATURES:

- Off-the-job coverage
- Guaranteed Issue coverage, no medical questions
- Coverage available for spouse and child(ren)
- Premiums remain the same
- Pays in addition to any other benefits
- Coverage is portable

Monthly Rates

EE Only	EE + SP	EE + CH	FAM
$8.80	$20.29	$24.99	$33.15

Group Voluntary Critical Illness

How Does Critical Illness Insurance Work:
You select the benefit coverage amount you want based on your individual need of either 10,000 or 20,000. If you have covered family members, our coverage also provides cash benefits for them. Then, if diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition.

100% Payout

- Heart attack
- Stroke
- Invasive Cancer
- Major organ transplant
- End stage renal failure
- Paralysis
- Benign brain tumor
- Coma
- Blindness*
- Loss of hearing*

25% Payout

- Coronary bypass surgery
- Advanced Alzheimer's
- Advanced Parkinson's
- Carcinoma in situ

Waiver of Premium

- Pays employee's premium when disabled

KEY FEATURES:

- Guaranteed Issue during initial enrollment - no health questions
- Wellness Benefit – pays $50 benefit for any 1 of 22 covered screening tests performed
- Additional occurrence - benefits paid for each covered illness provided 90 days or more separation between diagnoses.
- 2nd event - benefits paid for recurrence of same illness provided 12 months or more separation between diagnoses.
- Covered dependents receive 50% of the employee basic benefit amount and 100% of Wellness
- Benefits paid directly to insured, unless assigned to someone
- Premiums based on your age as of effective date and do not increase as you get older
- Coverage is portable. Once ported, coverage may continue up to age 70 or 3 years if greater

Group Voluntary Critical Illness

$10,000 Benefit
Monthly Rates: Non-Smoker/Smoker

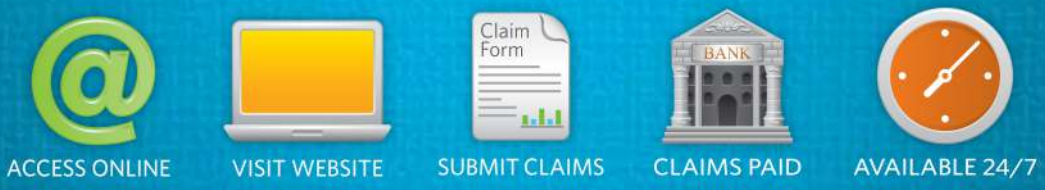
Non-Smoker Age	EE Only EE+CH	EE+Sp Family		Smoker Age	EE Only EE+CH	EE+Sp Family
18-29	$5.34	$8.63		18-29	$7.82	$12.35
30-39	$9.35	$14.65		30-39	$14.49	$22.36
40-49	$17.07	$26.22		40-49	$30.11	$45.78
50-59	$30.07	$45.74		50-59	$50.67	$76.63
60-63	$48.72	$73.71		60-63	$83.37	$125.69
64+	$63.69	$96.15		64+	$110.09	$165.77

$20,000 Benefit
Monthly Rates: Non-Smoker/Smoker

Non-Smoker Age	EE Only EE+CH	EE+Sp Family		Smoker Age	EE Only EE+CH	EE+Sp Family
18-29	$9.43	$14.77		18-29	$14.41	$22.23
30-39	$17.47	$26.82		30-39	$27.73	$42.22
40-49	$32.92	$49.99		40-49	$58.96	$89.07
50-59	$58.93	$89.00		50-59	$100.08	$150.75
60-63	$96.20	$144.92		60-63	$165.50	$248.87
64+	$126.13	$189.82		64+	$218.93	$329.02

Welcome to MyBenefits

Benefits at your fingertips



Accessing your benefit information has never been easier

MyBenefits is an easy-to-use website that offers you 24/7 access to important information pertaining to your benefits.

It only takes a few minutes to get access

Go to:
www.allstatebenefits.com/mybenefits
to sign up for access to use our secure online registration system.

Follow the steps listed to the right.

Need Help Registering?

Once you access the site, click on "Need Help" in the menu to the right of the screen.

Benefits

- Express Wellness - Submit your wellness benefit claim in 3 easy steps
- Direct deposit available for faster processing
- Submit/check claim status
- View full policy/certificate and claim history
- Make changes to personal information
- View and download your Explanation of Benefits (EOB)

Registration Steps

- Go to www.allstatebenefits.com/mybenefits
- Sign-up for access using the secure online registration process and create an online user ID and Password
- Be prepared to provide your Social Security number, zip code and birthdate
- It's that simple!

To find out more about what the **MyBenefits** site can offer, see the information on reverse.

Allstate BENEFITS

www.allstatebenefits.com/mybenefits

ABJ19459-2

MyBenefits

Innovative online capabilities at your fingertips

1. Online Access 24/7 -

Access your claim and benefit information anytime, night or day.

2. Claims Status, Filing and Payments -

Check claims status at your convenience 24/7. Or, file a claim using our online forms submission process and upload all supporting documents.

3. Express Wellness -

Have your wellness claim processed within 48 hours by filing through our Express Wellness option. Elect to have your claim benefit payment directly deposited into your checking account.

4. Policy Information -

Print or view policy information, coverage details or certificates on existing coverage.

5. Update Information -

Keep your physical address, email address and telephone number up-to-date and accept electronic delivery of documents.

6. Need Help? -

Contact information is available if more help is needed.

Allstate BENEFITS

For questions, please contact the Allstate Benefits Customer Care Center at **1-800-521-3535**

This material is valid as long as information remains current, but in no event later than October 1, 2016.

Trustmark
Universal Life Events

Customer Service: 1-800-918-8877
Email: customercare@trustmarksolutions.com
Website: www.trustmarksolutions.com

Life Events is a permanent life insurance that helps shield your family from financial hardship should something happen to you or your spouse.

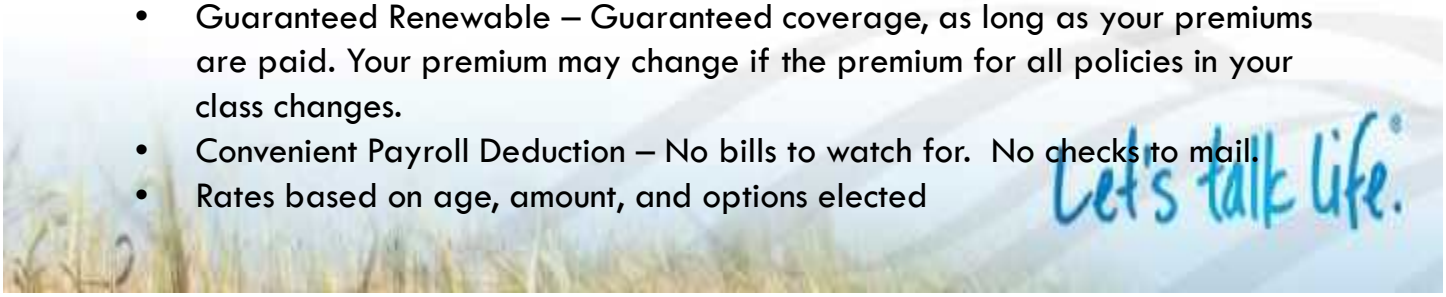
How does it work?

The main reason people have life insurance is for the death benefit. A death benefit puts money in your family's hands quickly when they need it most. It is money they can use any way they want to help with expenses such as:

- Funeral costs
- Rent or mortgages
- A college education for your children or grandchildren
- Household debt
- Retirement and more

Features you'll appreciate:

- Guarantee Issue defined benefit amount up to $50,000
- Lifelong Protection – Provides coverage that will last your lifetime.
- Builds Cash Value – Can access for life's challenges
- Family Coverage – Apply for your spouse even if you choose not to participate. Dependent children and grandchildren may be covered under a Universal Life policy.
- Terminal Illness Benefit – Accelerates up to 75% of your death benefit if your doctor determines your life expectancy is 24 months or less.
- Long Term Care Benefit – Accelerates 4% each month up to 25 months without decreasing death benefit amount
- Portability – Take your coverage with you and pay the same premium if you change jobs or retire.
- Guaranteed Renewable – Guaranteed coverage, as long as your premiums are paid. Your premium may change if the premium for all policies in your class changes.
- Convenient Payroll Deduction – No bills to watch for. No checks to mail.
- Rates based on age, amount, and options elected



CUSTOMER SERVICE CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

MEDICAL:
Company Name: Gravie
Phone Number: 855-451-8365
Website: www.gravie.com

DENTAL:
Company Name: Delta Dental of Iowa
Phone Number: 800-544-0718
Website: www.deltadentalia.com

VOLUNTARY VISION:
Company Name: Vision Service Plan (VSP)
Phone Number: 800-877-7195
Website: www.vsp.com

FLEXIBLE SPENDING ACCOUNTS (FSA):
Company Name: iSolved
Phone Number: 515-224-9400
Website: www.isolvedbenefitservices.com/kabel

LIFE/AD&D/VTL/LONG-TERM DISABILITY:
Company Name: Madison National
Phone Number: 800-597-2341
Website: www.madisonlife.com

VOLUNTARY ACCIDENT AND CRITICAL ILLNESS:
Company Name: Allstate
Phone Number: 877-810-2920
Website: www.allstate.com

VOLUNTARY UNIVERSAL LIFE:
Company Name: Trustmark
Phone Number: 800-918-8877
Website: www.trustmarksolutions.com

EMPLOYEE ASSISTANCE PROGRAM:
Company Name: Employee & Family Resources (EFR)
Phone Number: 800-327-4692
Website: www.efr.org

HOLMES MURPHY CONTACTS

Group Products:	**Please Contact:**
Medical Dental Voluntary Vision Flexible Spending Account Life/Disability Employee Assistance Program Accident Critical Illness Universal Life	Contact 1: Name: Rachel Kain Phone: 515-223-6909 Email: rkain@holmesmurphy.com Contact 2: Name: Amanda Bellville Phone: 515-223-6825 Email: abellville@holmesmurphy.com

Holmes Murphy & Associates has assembled the finest staff of benefits professionals whose expertise is matched by their intelligence and integrity. We further arm them with continuous education, training, and cutting-edge technical resources. These highly specialized consultants have helped us build our reputation for excellence and fuel our growth.

HOLMES MURPHY

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide 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 Guide 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 your Guide, please refer to your Employee Manual for additional information or contact your benefits manager.

IMPORTANT NOTICE FROM LEWIS CENTRAL COMMUNITY SCHOOL DISTRICT 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 Lewis Central Community School District 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. Lewis Central Community School District has determined that the prescription drug coverage offered by Gravie/Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Lewis Central Community School District coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Lewis Central Community School District coverage, be aware that you and your dependents may be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Lewis Central Community School District 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 November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Lewis Central Community School District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	July 1, 2023
Name of Entity/Sender:	Lewis Central Community School District
Contact--Position/Office:	Jennifer Wright, HR Generalist
Address:	4121 Harry Langdon Blvd. Council Bluffs, IA 51503
Phone Number:	(712) 366-8204

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage (including Medicaid and State Child Health Coverage)
If you are declining coverage for yourself or your dependents (including 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 you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption
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, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or State Child Health Coverage
If you or your dependents lose eligibility for coverage under Medicaid or State Child Health Coverage Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP or the determination of eligibility for a premium assistance subsidy.

> Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is 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.

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.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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 percent (as adjusted each year after 2014) 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. (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.)

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 Lewis Central Community School District's Administrative Office.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PRIVACY NOTICE

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 health and claims records
You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations.

We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us using the information on page 1.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

We will not retaliate against you for filing a complaint.

YOUR CHOICES

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

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

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

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

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan, so we can arrange additional services.

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.

Other Instructions for Notice

- July 1, 2023
- Jennifer Wright, HR Generalist
- Lewis Central Community School District
- 4121 Harry Langdon Blvd
- Council Bluffs, IA 51503
- 712-366-8204
- Jennifer.Wright@LewisCentral.org

Holmes Murphy & Associates has assembled the finest staff of benefits professionals whose expertise is matched by their intelligence and integrity. We further arm them with continuous education, training, and cutting-edge technical resources. These highly specialized consultants have helped us build our reputation for excellence and fuel our growth.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide 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 Guide 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 your Guide, please refer to your Employee Manual for additional information or contact your benefits manager