



BENEFITS OVERVIEW

Prepared by Kraus-Anderson Insurance

PLAN YEAR: 2025/2026



Address

1380 Energy Lane, Suite 108
Bloomington, MN 55420



Phone

Main: 651-478-4535



Online

Website: www.newcenturyschool.net

WELCOME NOTE

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

PLAN YEAR July 1, 2025 through June 30, 2026

EXISTING EMPLOYEES – DURING ANNUAL OPEN ENROLLMENT

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

NEWLY HIRED EMPLOYEES – DURING YOUR INITIAL BENEFITS ELIGIBILITY PERIOD

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

EMPLOYEE ELIGIBILITY

- You are scheduled to work 30 hours per week
- Coverage goes into effect on the first day of the month following 30 days of employment

ELIGIBLE DEPENDENTS

- Your legally married spouse
- Your child(ren) up to age 26

CHANGES DURING THE YEAR - QUALIFYING LIFE EVENTS

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

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

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

CONTACTS

	INSURANCE CARRIER	CARRIER INFORMATION	PLAN INFORMATION
	MEDICAL: UnitedHealthcare	866-414-1959 www.uhc.com Click here to find provider	Group Number: Network:
	PHARMACY: UnitedHealthcare	866-414-1959 www.uhc.com Click here to find pharmacy	Rx Group: United Rx Rx Bin: 610279 Rx PCN: 9999
	HEALTH SAVINGS ACCOUNT (HSA): Further by HealthEquity	800-859-2144 www.hellofurther.com Register here	Group Number: 013889
	TELE-MEDICINE: HealthiestYou by Teladoc	866-703-1259 www.healthiestyou.com Register here	Group Number: HY9690
	DENTAL: Lincoln Financial	800-423-2765 www.lfg.com Click here to find provider	Group Number: 1131258
	VISION: MetLife	800-942-0854 www.metlife.com Click here to find provider	Group Number: 05369951
	LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D): Lincoln Financial	800-423-2765 www.lfg.com Member Login	Group Number: 1131258
	SHORT-TERM & LONG-TERM DISABILITY: Lincoln Financial	800-423-2765 www.lfg.com Member Login	Group Number: 1131258
	PLAN ADMINISTRATOR: Deema Sorri	651-478-4535	business@newcenturyschool.net

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

MEDICAL

Surest is a unique health insurance program that makes managing your healthcare simple and flexible. Here's how it works:

- **Variety of Services:** Surest offers copays for different office visits and services.
- **Flexible Costs:** The copays vary based on where you get your care. This unique plan does **not** have a deductible.
- **Easy Search:** Use the Surest App to quickly find providers and see your copay options.

Plan Options	UHC \$2,000 – 100% HSA Plan		Surest through UHC C5000	
	Individual	Individual	Individual	Family
Deductible Calendar Year	\$2,000	\$4,000	\$0	\$0
Preventive Care www.healthcare.gov for covered screenings	No charge		No charge	
Coinsurance	0% after deductible		N/A	
Out of Pocket Maximum	\$3,000	\$6,000	\$5,000	\$10,000
Office Visit	0% after deductible		Primary/Specialist care: \$20-\$105 Urgent care: \$60 copay X-ray & Lab: \$0 copay	
Prescription Drug Coverage	Tier 1: \$10 copay Tier 2: \$35 copay Tier 3: \$60 copay		Tier 1: \$20 copay Tier 2: \$90 copay Tier 3: \$150 copay	
	Check member services for pharmacies within your network			
Plan Cost	Total Monthly Premium	Employee Monthly Premium	Total Monthly Premium	Employee Monthly Premium
Employee	\$710.70	\$106.61	\$649.73	\$97.46
Employee + Spouse	\$1,719.89	\$1,031.93	\$1,572.35	\$943.41
Employee + Child(ren)	\$1,286.37	\$771.82	\$1,176.01	\$705.61
Family	\$2,366.63	\$1,419.98	\$2,163.60	\$1,298.16

Refer to the carrier Summary Benefits of Coverage (SBC) for specific details.

HEALTH SAVINGS ACCOUNT (HSA)

2025 Maximum Contributions	2026 Maximum Contributions
Individual: \$4,300 per calendar year	Individual: \$4,400 per calendar year
Family: \$8,550 per calendar year	Family: \$8,750 per calendar year
55+ may contribute an additional \$1,000 per calendar year	
Eligible Expenses: Please refer to section 213(d) of the Internal Revenue Code, can be found at www.irs.gov	

TELE-MEDICINE – HEALTHIESTYOU

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

DENTAL

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

Dental	Lincoln Financial	
	In Network	Out of Network
Network		
Individual Deductible	\$25	\$50
Family Deductible	\$75	\$150
Annual Maximum (per person)	\$2,000	\$1,500
Preventive Services	100%	100%
Basic Services	80%	60%
Major Services	50%	50%
Orthodontia Services (dependent children ages 8-18)	\$2,000 Lifetime Maximum	\$1,500 Lifetime Maximum
Plan Cost	Total Monthly Premium	Employee Monthly Premium
Employee Only	\$36.93	\$12.93
Employee + 1	\$78.83	\$49.83
Family	\$142.50	\$118.50

Refer to the carrier summary for specific details.

VISION

Coverage is voluntary and 100% paid by the employee. Eligible dependents may participate in the plan and those costs are the responsibility of the employee.

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

Refer to the carrier summary for specific details.

TERM LIFE AND AD&D (ACCIDENTAL DEATH & DISMEMBERMENT)

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

VOLUNTARY TERM LIFE AND AD&D

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

DISABILITY

Employer contributes 100% to the employee's monthly premiums. Eligible dependents may participate in the plan and those costs are the responsibility of the employee.

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

Refer to the carrier summary for specific details.

VOLUNTARY METLAW

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



**ADDITIONAL
INFORMATION
AND SERVICES**

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-633-2446 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$2,000 Individual / \$4,000 Family Out-of-Network: \$5,000 Individual / \$10,000 Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive Care Services</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your deductible. See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: \$3,000 Individual / \$6,000 Family Out-of-Network: \$10,000 Individual / \$20,000 Family Per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limits</u> must be met
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Virtual Visits - 0% <u>coinsurance</u> by a Designated Virtual <u>Network Provider</u> . Office Visit cost share applies to any other Telehealth service based on <u>provider</u> type. No virtual coverage <u>out-of-network</u> .
	<u>Specialist visit</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No Charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. No coverage <u>out-of-network</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	Lab Testing: 30% <u>coinsurance</u> X-Ray/Diagnostics: Mammogram; additional diagnostic services and testing after a mammogram: 0% <u>coinsurance</u> Other x-rays and diagnostic testing: 30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at welcometouhc.com	Tier 1 - Your Lowest Cost Option	Retail: \$10 <u>copay</u> Mail-Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. Tier 1 Insulin is No Charge. Retail: Tier 2 Insulin is \$15 per Prescription Order or Refill, <u>deductible</u> does not apply. Mail-Order: Tier 2 Insulin is \$30 per Prescription Order or Refill, <u>deductible</u> does not apply. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Prescription drug costs are subject to the annual <u>deductible</u> . <u>Network deductible</u> will be applied to the <u>out-of-network provider</u> and applies to the <u>Network out-of-pocket limit</u> .
	Tier 2 - Your Mid-Range Cost Option	Retail: \$35 <u>copay</u> Mail-Order: \$87.50 <u>copay</u>	Retail: \$35 <u>copay</u>	
	Tier 3 - Your Mid-Range Cost Option	Retail: \$60 <u>copay</u> Mail-Order: \$150 <u>copay</u>	Retail: \$60 <u>copay</u>	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	0% <u>coinsurance</u>	*0% <u>coinsurance</u>	* <u>Network deductible</u> applies.
	Emergency medical transportation	0% <u>coinsurance</u>	*0% <u>coinsurance</u>	* <u>Network deductible</u> applies.
	Urgent Care	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Network All Other</u> : 0% <u>coinsurance</u> . See your policy or <u>plan</u> document for additional information about EAP benefits.
	Inpatient services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . See your policy or <u>plan</u> document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient <u>Preauthorization</u> applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> .

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 visits per calendar year. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limits per calendar year: Physical, Occupational, Speech: 52 visits each; Cardiac: 36 visits; Pulmonary: 20 visits.
	<u>Habilitative services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 days per calendar year, combined with inpatient rehabilitation. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Preauthorization</u> is required <u>out-of-network</u> for DME over \$1,000 or no coverage.
	<u>Hospice services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> .
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

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.)

- Bariatric surgery
- Cosmetic Surgery
- Dental Care
- Glasses
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine Eye Care
- Routine foot care - Except as covered for Diabetes
- Weight loss programs

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

- Acupuncture - 52 visits per calendar year
- Chiropractic (manipulative) care - 52 visits per calendar year
- Hearing aids

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Minnesota Department of Commerce at 1-800-657-3602 or <http://mn.gov/commerce>.

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 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-633-2446.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-633-2446.

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

About these Coverage Examples:



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

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$2,000	■ The plan's overall deductible	\$2,000	■ The plan's overall deductible	\$2,000
■ Specialist coinsurance	0%	■ Specialist coinsurance	0%	■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%	■ Other coinsurance	0%	■ Other coinsurance	0%
This EXAMPLE event includes services like: Specialist office visits (<i>pre-natal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,000	<u>Deductibles</u>	\$1,700	<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$10	<u>Copayments</u>	\$0	<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$2,070	The total Joe would pay is	\$1,700	The total Mia would pay is	\$2,000

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

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [Join.Surest.com](https://www.join-surest.com) or by calling Surest Member Services at 1-866-683-6440. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Yes. This <u>plan</u> does not have a <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For <u>network providers</u> : \$5,000 Individual / \$10,000 Family For <u>out-of-network providers</u> : \$10,000 Individual / \$20,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See Join.Surest.com , or call 1-866-683-6440 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 - \$105 copay / visit	\$215 copay / visit	Certain procedures performed in the office may have a higher office visit copay . Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. Office Visit cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional copays may apply.
	Specialist visit	\$20 - \$105 copay / visit	\$215 copay / visit	
	Preventive care/ screening/ immunization	No Charge	No Charge	
If you have a test	Diagnostic test (x-ray, blood work)	Routine diagnostic test : No Charge Non-routine diagnostic test : \$20 - \$1,050 copay / visit	Routine diagnostic test : No Charge Non-routine diagnostic test : Up to \$2,400 copay / visit	Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. Preauthorization required for certain services for out-of-network or there is no coverage.
	Imaging (CT/PET scans, MRIs)	\$125 - \$850 copay / visit	Up to \$1,650 copay / visit	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Optumrx.com	Tier 1 (Generic drugs)	30-Day Supply \$20 <u>copay</u>	Not Covered	Certain Tier 1 drugs are available with \$0 <u>copays</u> , including prescribed generic contraceptives and tobacco cessation medications. Tier 1 Insulin is No Charge. Retail: Tier 2 Insulin is \$15 per <u>Prescription</u> Order or Refill. Mail-Order: Tier 2 Insulin is \$37.50 per <u>Prescription</u> Order or Refill. To learn more about drug tiers and about <u>copays</u> for specific drugs, visit Optumrx.com . <u>Preauthorization</u> is required for certain drugs or may result in a higher cost.
		90-Day Supply \$50 <u>copay</u>		
	Tier 2 (Preferred brand drugs)	30-Day Supply \$90 <u>copay</u>	Not Covered	
		90-Day Supply \$225 <u>copay</u>		
	Tier 3 (Non-preferred brand drugs)	30-Day Supply \$150 <u>copay</u>	Not Covered	
90-Day Supply \$375 <u>copay</u>				
<u>Specialty drugs</u>	30-Day Supply Tier 1: \$20 <u>copay</u> Tier 2: \$200 <u>copay</u> Tier 3: \$500 <u>copay</u>	Not Covered	<u>Specialty drugs</u> are not covered at a 90-day supply. <u>Preauthorization</u> is required for certain <u>specialty drugs</u> or may result in a higher cost.	

*For more information about limitations and exceptions, see [plan](#) or policy document at Join.Surest.com for prospective members.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$35 - \$3000 <u>copay</u> / visit	Up to \$9000 <u>copay</u> / visit	<p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.</p>
	Physician/surgeon fees	No Charge	No Charge	
If you need immediate medical attention	<u>Emergency room care</u>	\$600 <u>copay</u> / visit	\$600 <u>copay</u> / visit	<p><u>Copay</u> is waived if admitted within 24 hours. Out-of-network <u>emergency room care</u> visit <u>copay</u> applies to the in-network <u>out-of-pocket</u> limit.</p>
	<u>Emergency medical transportation</u>	\$350 <u>copay</u> / transport	\$350 <u>copay</u> / transport	<p>Out-of-network <u>emergency medical transportation</u> <u>copay</u> applies to the in-network <u>out-of-pocket</u> limit.</p>
	<u>Urgent care</u>	\$60 <u>copay</u> / visit	\$180 <u>copay</u> / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 - \$3,000 <u>copay</u> / stay	Up to \$9,000 <u>copay</u> / stay	<p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.</p>
	Physician/surgeon fees	No Charge	No Charge	

*For more information about limitations and exceptions, see plan or policy document at Join.Surest.com for prospective members.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Home/Office: \$20 <u>copay</u> / visit Outpatient Facility: \$130 <u>copay</u> / visit	Home/Office: \$160 <u>copay</u> / visit Outpatient Facility: \$390 <u>copay</u> / visit	Certain procedures/services in the outpatient setting may have a lower <u>copay</u> . <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	Inpatient services	\$2,000 <u>copay</u> / stay	\$6,000 <u>copay</u> / stay	Certain procedures/services in the inpatient setting may have a lower <u>copay</u> . <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
If you are pregnant	Office visits	No Charge	No Charge	<u>Cost sharing</u> does not apply to <u>preventive services</u> with <u>network providers</u> . Depending on the type of service, a <u>copay</u> may apply.
	Childbirth/delivery professional services	No Charge	No Charge	One <u>copay</u> for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother. <u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care. <u>Preauthorization</u> required for <u>out-of-network</u> inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there is no coverage.
	Childbirth/delivery facility services	\$900 - \$2,000 <u>copay</u> / stay	\$6,000 <u>copay</u> / stay	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$60 <u>copay</u> / visit	\$180 <u>copay</u> / visit	Limited to 120 visits per person per <u>plan</u> year. <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	<u>Rehabilitation services</u>	\$10 - \$130 <u>copay</u> / visit	Up to \$240 <u>copay</u> / visit	Limits per person per <u>plan</u> year: Occupational, physical and speech therapy: 60 visits each.
	<u>Habilitation services</u>	\$10 - \$130 <u>copay</u> / visit	Up to \$240 <u>copay</u> / visit	Visits limits for physical, occupational and speech therapy do not apply for the treatment of mental illness or substance-related & addictive disorders, including autism. Limits are a combination of <u>network providers</u> and <u>out-of-network providers</u> per person per <u>plan</u> year. <u>Copays</u> are listed as a range. Providers are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.
	<u>Skilled nursing care</u>	\$1,500 <u>copay</u> / stay	\$4,500 <u>copay</u> / stay	Limited to 120 days per person per <u>plan</u> year. <u>Preauthorization</u> required for certain services for <u>out-of-network</u> or there is no coverage.
	<u>Durable medical equipment</u>	\$0 - \$1,000 <u>copay</u> / equipment based on DME tier	Up to \$2,000 <u>copay</u> / equipment based on DME tier	For <u>durable medical equipment (DME)</u> tiers and limitations, visit Join.Surest.com . <u>Preauthorization</u> required for certain DME for <u>out-of-network</u> or there is no coverage.
	<u>Hospice services</u>	Home: \$60 <u>copay</u> / visit Inpatient: \$2,000 <u>copay</u> / stay	Home: \$180 <u>copay</u> / visit Inpatient: \$6,000 <u>copay</u> / stay	<u>Preauthorization</u> required for <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or there is no coverage.
If your child needs dental or eye care	Children's eye exam	No Charge	\$215 <u>copay</u> / visit	Limited to 1 exam every year.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

*For more information about limitations and exceptions, see plan or policy document at Join.Surest.com for prospective members.

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.)

- | | | |
|---------------------|--|--|
| • Bariatric surgery | • Infertility treatment | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine foot care (except as covered for certain conditions) |
| • Dental care | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

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

- | | | |
|--|----------------|--|
| • Acupuncture - 60 visits per <u>plan</u> year | • Hearing aids | • Routine eye care (Adult) - 1 exam per <u>plan</u> year |
| • Chiropractic care - 60 visits per <u>plan</u> year | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact Surest Member Services at 1-866-683-6440. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Surest Member Services at 1-866-683-6440; or www.dol.gov/ebsa/healthreform or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or the Minnesota Department of Commerce at 1-800-657-3602 or www.mn.gov/commerce.

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 1-866-683-6440.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-683-6440.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-683-6440.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-683-6440 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-683-6440.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-683-6440.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-683-6440.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-683-6440.

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

About these Coverage Examples:



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

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

- **The plan's overall deductible** \$0
- **Specialist copayment** \$20 - \$105
- **Hospital (facility) copayment** \$200 - \$3,000
- **Other coinsurance** \$0

This EXAMPLE event includes services like:

- Specialist office visits (*pre-natal 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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$960

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

- **The plan's overall deductible** \$0
- **Specialist copayment** \$20 - \$105
- **Hospital (facility) copayment** \$200 - \$3,000
- **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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$600

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

- **The plan's overall deductible** \$0
- **Specialist copayment** \$20 - \$105
- **Hospital (facility) copayment** \$200 - \$3,000
- **Other coinsurance** \$0

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1100

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



Questions about your health plan? We've got answers.



Help is just a call away

Whether you have questions about a new claim, need to find a doctor or just want to better understand your benefits, our Advocates are here to help. Connect with our team for help finding care for your needs, walking through a bill, accessing additional plan resources and more.

We simplify the health care experience to help you:



Understand your benefits and claims



Learn more about your prescriptions*



Get answers about a bill or payment



Find support if you have a child with complex needs**



Locate care and cost options



Discover your plan's health and well-being benefits

We're dedicated to giving you the information you need to get the most out of your benefits—and your health.

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Try 24/7 Virtual Visits to speak with a doctor anytime, from virtually anywhere, using a mobile device or computer. To get started, sign in at myuhc.com®.

Connect with us

Call the number on your health plan ID card or sign in to myuhc.com and click on **Call** or **Chat**

United Healthcare

*For members with OptumRx®.

**Qualifying members are eligible for our Special Needs Initiative program; eligibility criteria can be determined by calling the number on your health plan ID card.

This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through the program is for informational purposes only and provided as part of your health plan. Wellness nurses, coaches and other representatives cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. The program is not an insurance company and may be discontinued at any time. Additionally, if there is any difference between the information and your coverage documents (Summary Plan Description, Schedule of Benefits, and any attached Riders and/or Amendments), your coverage documents govern.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

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Make the connection with Calm Health.



The Calm Health app provides programs and tools to help support your mental health and well-being – all at your own pace. As a UnitedHealthcare member, Calm Health is included in your health plan and available at no additional cost.

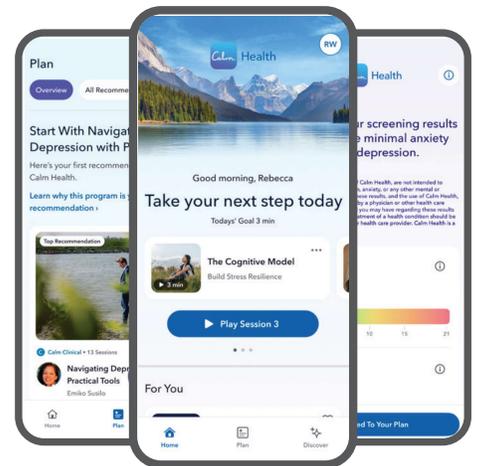
Resources to help support your mental health

To help tailor your Calm Health experience, you'll begin with a short mental health screening. Then, Calm Health will suggest certain programs for you to consider based on where you are in your well-being journey.

Tap into tools and support

The Calm Health app brings you a library of support – including mindfulness content and programs created by psychologists – for a variety of health experiences and life stages. This information is designed to help you:

- **Learn techniques to improve well-being** – Find tools, music and sounds to help you meditate, improve focus, move mindfully and feel calm
- **Work toward goals** – Join self-guided self-care programs, and track your progress along the way
- **Support your mind and body** – Access mental health information and support to help you strengthen the mind-body connection



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- Offering specialized help in improving relationships at home or work
- Providing guidance on legal and financial concerns
- Finding ways to help you cope with occupational stress and burnout
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1-888-887-4114**

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The material provided through this program is for informational purposes only. EAP staff cannot diagnose problems or suggest treatment. EAP is not a substitute for your doctor's care. Employees are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. EAP is not an insurance program and may be discontinued at any time. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

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- Pregnancy in the Second Trimester
- Pregnancy in the Third Trimester
- Postpartum: The Fourth Trimester after Pregnancy
- Exploring Breastfeeding

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Explore maternity courses

Visit myuhc.phs.com/pregnancy-resources

The information provided under maternity support is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. UnitedHealthcare makes no representation or warrant with regard to the accuracy of the information presented. If you believe that you may have any emergency medical condition you should immediately call 9-1-1. Participants should consult an appropriate health care professional to determine what may be right for them. If you have questions about the information presented or questions about health care services, supplies, or treatments, you should consult your health care provider before making any health care decisions. Employers are responsible for ensuring that any wellness programs they offer to their employees comply with applicable state and/or federal law, including, but not limited to, GINA, ADA and HIPAA wellness regulations, which in many circumstances contain maximum incentive threshold limits for all wellness programs combined that are generally limited to 30% of the cost of self-only coverage of the lowest-cost plan, as well as obligations for employers to provide certain notices to their employees. Employers should discuss these issues with their own legal counsel.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

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**United
Healthcare**



Flexible, accessible health options for employees



Half of U.S. consumers report wellness as a top priority in their daily lives.¹ One Pass Select™ is designed to help make it easier for your employees to prioritize their health and wellness through a lower-cost, extensive nationwide gym network – including digital fitness. Best of all, your employees have the freedom to choose the option that fits their needs and lifestyle.



average retail gym membership savings with One Pass Select³

See the benefits of One Pass Select



Potential increased productivity

Studies show that healthier employees are typically more productive²



No cost to you, low cost to your employees

Allows you to offer various fitness pricing options and competitive, flexible health options so employees can choose what's best for them



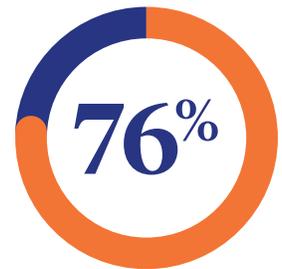
A simple digital experience

Easy access through UnitedHealthcare Rewards on the **UnitedHealthcare® app** or **myuhc.com®** to browse membership options, a fitness directory and more



UHC Rewards integration

Employees can redeem UHC Rewards dollars to use toward a One Pass Select subscription

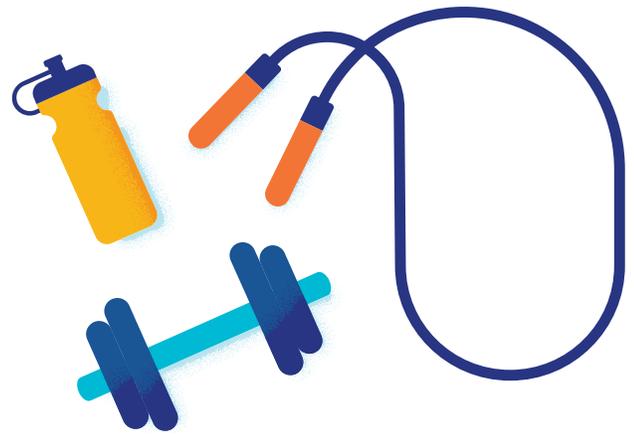


of employees who signed up for One Pass Select were actively engaged in the program⁴

More advantages for employees

One Pass Select offers employees various membership tiers to choose from based on their unique fitness goals – along with additional benefits, including:

- No long-term contracts or annual gym registration fees
- Flexible fitness options with the ability to change tiers monthly
- Multisite access nationwide with no waiting period
- The ability to add up to 4 family members (ages 18+)



Membership options for employees

Category	Digital	Classic	Standard	Premium	Elite
Monthly fee	\$10	\$34	\$69	\$109	\$159
One-time enrollment fee	\$10	\$29	\$29	\$29	\$29
Gym network size		11,000+	14,000+	16,000+	20,000+
Premium network			✓	✓	✓
Multisite access		✓	✓	✓	✓
Digital classes	23,000+	23,000+	23,000+	23,000+	23,000+
On demand	✓	✓	✓	✓	✓
Living streaming	✓	✓	✓	✓	✓
Workout builder	✓	✓	✓	✓	✓
Family memberships*	✓	✓	✓	✓	✓
Upgrade/downgrade	✓	✓	✓	✓	✓
Cancel within 30 days	✓	✓	✓	✓	✓

* 10% discount

Learn more

Contact your UnitedHealthcare representative

United
Healthcare®

¹ McKinsey & Company. Still feeling good: The US wellness market continues to boom. [mckinsey.com/industries/consumer-packaged-goods/our-insights/still-feeling-good-the-us-wellness-market-continues-to-boom](https://www.mckinsey.com/industries/consumer-packaged-goods/our-insights/still-feeling-good-the-us-wellness-market-continues-to-boom). Sept. 12, 2022.

² Centers for Disease Control and Prevention. Increase Productivity. [cdc.gov/workplacehealthpromotion/model/control-costs/benefits/productivity.html](https://www.cdc.gov/workplacehealthpromotion/model/control-costs/benefits/productivity.html). Accessed February 2023.

³ One Pass Select Internal Analytics/Book of Business, 2022.

⁴ One Pass Select Utilization Report, 2023.

One Pass Select is a voluntary program featuring a subscription-based nationwide gym network. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships under this program. One Pass Select is not available in HI, KS, NJ, VT and Puerto Rico for fully insured participants.

UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker, certain credits and/or rewards and/or purchasing an activity tracker with earnings may have tax implications. You should consult with an appropriate tax professional to determine if you have any tax obligations under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-855-256-8669 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Subject to HSA eligibility, as applicable. This program is not available in Hawaii, Vermont and Puerto Rico. Components subject to change.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

The path to quitting starts here



If you use tobacco and have thought about quitting, **Quit For Life® on Rally Coach™** may be able to help. Get tools and online resources designed to help you quit — and stay quit — at no additional cost.



Get coach support

Connect with a coach who will help create a personalized Quit Plan and guide you at every step



Access anytime, anywhere

Manage triggers with help from coach-led group sessions, trackers, text support, and more, all at your fingertips



View quit recommendations

Get real-life tips and plan your path to quit with recommended daily goals, articles and videos



Stay on track with **24/7** support

Quit For Life®

Get started

Go to [Myuhc.com](https://myuhc.com) > Coverage & Benefits > My Coverage & Benefits > Additional Benefits > View all additional benefits



This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this program is for informational purposes only as part of your health plan. Wellness coaches, nurses and other program representatives cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Please discuss with your doctor how the information provided may be right for you. Your health information is kept confidential in accordance with the law. The program is not an insurance program and may be discontinued at any time.

Administrative services provided by UnitedHealthcare Services, Inc. or their affiliates. Insurance coverage provided through UnitedHealthcare Insurance Company or its affiliates.

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Healthier habits, healthier lifestyle

Take small steps for lasting change with Real Appeal®, an online weight management support program.



Get healthier, at no additional cost to you

Real Appeal on Rally Coach™ is a proven weight management program designed to help you get healthier and stay healthier. It's available to you and eligible family members at no additional cost as part of your benefits.

Take small steps toward healthier habits

Set achievable nutrition, exercise and weight management goals that keep you motivated to create lasting change. Track your progress from your daily dashboard, too.

Support and community along the way

Feel supported with personalized messages, online group sessions led by coaches and a caring community of members.

Join today at enroll.realappeal.com or scan this code




Get a Success Kit delivered right to your door.

Make the most of tools and resources like weight and food scales, a portion plate and more. Your Success Kit is delivered after you attend your first live group session.

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Healthcare

Real
Appeal®

Real Appeal is a voluntary weight loss program that is offered to eligible members at no additional cost as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Results, if any, may vary. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

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Get in on UHC Rewards



Good news—your health plan comes with a new way to earn up to \$1,000. UnitedHealthcare Rewards is included in your health plan at no additional cost.



There's so much good to get

With UHC Rewards, a variety of actions—including many things you may already be doing—lead to rewards. The activities you go for are up to you—same goes for ways to spend your earnings. Here are some ways you can earn:

Reach daily goals

- Track 5,000 steps or 15 active minutes each day, or double it for an even bigger reward
- Track 14 nights of sleep

Complete one-time reward activities

- Go paperless
- Get a biometric screening
- Take a health survey
- Connect a tracker

Personalize your experience by selecting activities that are right for you—and look for new ways of earning rewards to be added throughout the year.

Earn up to
\$1,000

**United
Healthcare**

There are 2 ways to get started



On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select the **Menu** tab and choose **UHC Rewards**
- Activate UHC Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards
- Choose reward activities that inspire you—and start earning



Your health

Get in on an experience that's designed to help inspire healthier habits

Your goals

Personalize how you earn by choosing the activities that are right for you

Your rewards

Earn up to \$1,000 and use it however you want

Questions?

Call customer service at **1-866-230-2505**

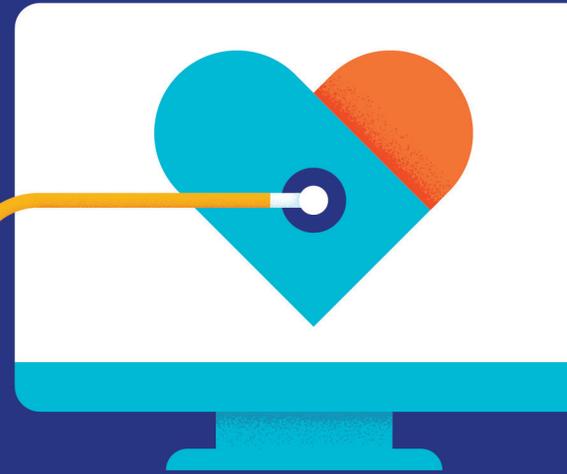
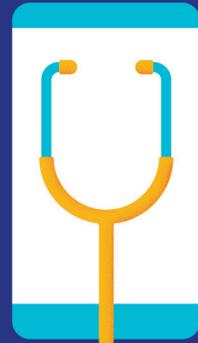
United Healthcare

UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker, certain credits and/or rewards and/or purchasing an activity tracker with earnings may have tax implications. You should consult with an appropriate tax professional to determine if you have any tax obligations under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Subject to HSA eligibility, as applicable. This program is not available in Hawaii, Kansas, Vermont and Puerto Rico. Components subject to change.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

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A health plan that's always with you

Digital tools to keep you connected

Get the most out of your benefits

Register for your personalized website on myuhc.com[®] and download the UnitedHealthcare[®] app. These digital tools are designed to help you understand your benefits and make informed decisions about your care.

- Find care and compare costs for providers and services in your network
- Check your plan balances, view your claims and access your health plan ID card
- Access wellness programs and view clinical recommendations
- 24/7 Virtual Visits – Connect with providers by phone or video* to discuss common medical conditions and get prescriptions;** if needed
- View your health care financial account(s) such as HSA, FSA or HRA
- Compare prescription costs and order refills



Download the app

Available for iPhone and Android

Register today



Scan the QR code or go to myuhc.com and click **Register Now**

See next page for registration steps

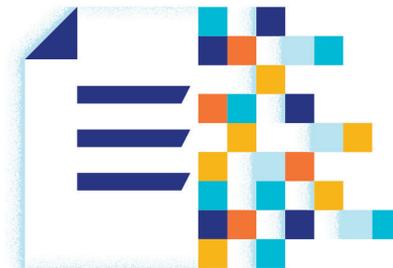
*Data rates may apply.

**Certain prescriptions may not be available, and other restrictions may apply.

continued

How to register

- 1 Go to myuhc.com or download the UnitedHealthcare app and click **Register Now**
- 2 Complete the required fields and create your username/password
- 3 Enter your contact information and security questions
- 4 Agree to the terms and conditions and select your email preferences
- 5 Go paperless—from your account settings, choose paperless in your communication preferences



Go paperless

- Less paper, less clutter
- Get your required communications online



Get started at myuhc.com

United
Healthcare

24/7 Virtual Visits is a service available with a provider via video, or audio-only where permitted under state law. It is not an insurance product or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under the Find Care & Costs section.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Health plan coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by All Savers Insurance Company (except CA, MA, MN, NJ and NY), UnitedHealthcare Insurance Company in MA and MN, UnitedHealthcare Life Insurance Company in NJ, UnitedHealthcare Insurance Company of New York in NY, and All Savers Life Insurance Company of California in CA.



Visit with a provider 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a provider by phone or video¹ through **myuhc.com**[®] or the UnitedHealthcare[®] app



Another way to get care

Providers can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,² if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually \$54 or less.³**

Consider 24/7 Virtual Visits for these common conditions and more

- Cough
- Fatigue/weakness
- Congestion/sinus pain
- Headache
- Nasal discharge
- Fever
- Sore throat
- Difficulty sleeping
- Loss of appetite

\$54 or less

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit—bringing a potential \$2,000⁴ cost down to \$54 or less

Get started

Sign in at myuhc.com/virtualvisits | Call the number on your health plan ID card | Download the UnitedHealthcare app

United Healthcare[®]

¹ Data rates may apply.

² Certain prescriptions may not be available, and other restrictions may apply.

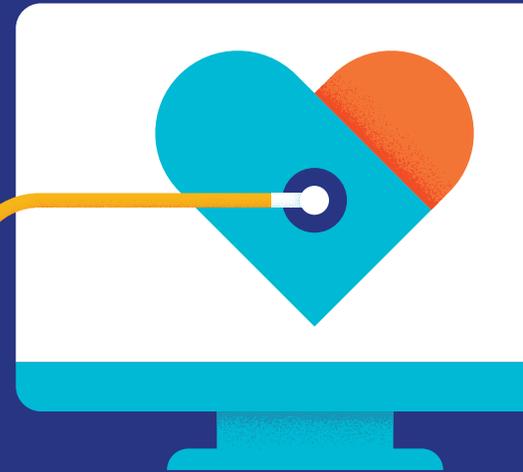
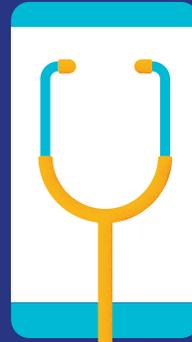
³ The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change.

⁴ Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated urgent care savings are based on a \$131 difference between an average urgent care visit cost of \$180 and a Virtual Visit cost of \$54; \$2,000 difference between the average emergency room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and are not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The UnitedHealthcare[®] app is available for download for iPhone[®] or Android[®]. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits is a service available with a Designated Virtual Network Provider via video, or audio-only where permitted under state law. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.



Activate your myuhc.com account

Put your health plan at your fingertips

Get the most out of your benefits

Your personalized website, myuhc.com[®], features tools designed to help you:

- **Find, price and save on care**—you can save with Virtual Visits* and other tools. You can save an average of 36%¹ when you compare costs for providers and services
- **Get care from anywhere** with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7
- **Understand your benefits** and the financial impact of care decisions
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status
- **Access claim details**, plan balances and your health plan ID card quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills**, get estimates and compare medication pricing**
- **Check your plan balances**, access financial accounts and more



Download the UnitedHealthcare[®] app

It's perfect for on-the-go access, help finding a nearby doctor and more.

*Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

** Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

Activation is quick

- 1** Go to myuhc.com > **Register Now**
- 2** Fill out the required fields and create your username/password
- 3** Enter your contact information and security questions
- 4** Agree to the website's policies and be sure to opt-in for email updates. We promise you'll only see our name in your inbox with relevant news and wellness updates



Scan the QR code with your smart phone to get started.



Get started at myuhc.com

**United
Healthcare**

¹ UnitedHealthcare Internal Claims Analysis, 2019.

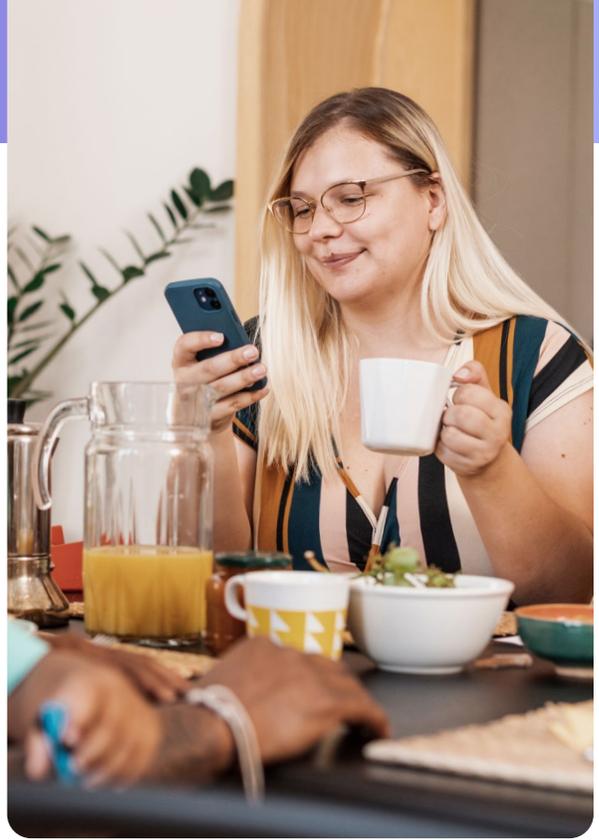
All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

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Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Rediscover your passion for health.

With One Pass Select™, we're on a mission to make fitness engaging for everyone. One Pass Select can help you reach your fitness goals, while finding new passions along the way. Find a routine that's right for you whether you work out at home or at the gym. Choose a membership tier that fits your lifestyle and provides everything you need for whole-body health in one easy, affordable plan. One Pass Select is available to you or your eligible family members (18+).



Find your fit with One Pass Select



At the gym

Choose from our large, nationwide network of gym brands and local fitness studios. Use any gym in the network and create a routine just for you.



In the kitchen*

Get groceries and household essentials delivered to your home. We make it easy to plan for everything you need to enjoy delicious, nutritious meals.



At home

Work out at home with live or on-demand online fitness classes. Try our workout builder to get routines created just for you, no matter what your fitness level and interests are.

\$34/Month

Classic | 12,000+ gym locations

\$69/Month

Standard | 14,000+ gym and premium locations

\$109/Month

Premium | 16,000+ gym and premium locations

\$159/Month

Elite | 20,000+ gym and premium locations

- An enrollment fee may apply, or get started with a digital-only plan for \$10/Month.
- All tiers Classic or above include the digital tier, grocery delivery*, and additional benefits at no extra cost.



Enroll today

Scan QR code below or visit OnePassSelect.com.



*Grocery services not available to fully insured groups in TX.

One Pass Select is a voluntary program featuring a subscription-based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum.

Insurance coverage for fully insured plans is provided by All Savers Insurance Company (for FL, GA, OH, UT and VA), by UnitedHealthcare Insurance Company of IL (for IL), by UnitedHealthcare of Kentucky, Ltd. (for KY), or by UnitedHealthcare Insurance Company (for AL, AR, AZ, CO, DC, DE, GA, IA, ID, IL, IN, KS, KY, LA, MI, MN, MO, MS, MT, NC, NE, NH, NV, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, WI, WV and WY). These policies have exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or the company. Administrative services for insurance products underwritten by All Savers Insurance Company and UnitedHealthcare Insurance Company, and for self-funded plans, are provided by Bind Benefits, Inc. d/b/a Surest, its affiliate UnitedHealthCare Services, Inc., or by Bind Benefits, Inc. d/b/a Surest Administrators Services, in CA. © Bind Benefits, Inc., d/b/a Surest. All rights reserved. B2C_24-AI-868121_1024

PIVOT®

Smoking • Vaping • All Tobacco

Quit on Your Terms



Pivot first, quit when you're ready.

If you or someone you know would like to quit tobacco, Pivot is available for \$0 copay for eligible Surest members ages 18+.



Pivot makes the journey easier

Personalized and non-judgmental, Pivot offers a choice of tools and support.

- Pivot App
- SmartSensor*
- Free supply of Nicotine Replacement Therapy (NRT)*
- Unlimited access to personal coaching
- Online community

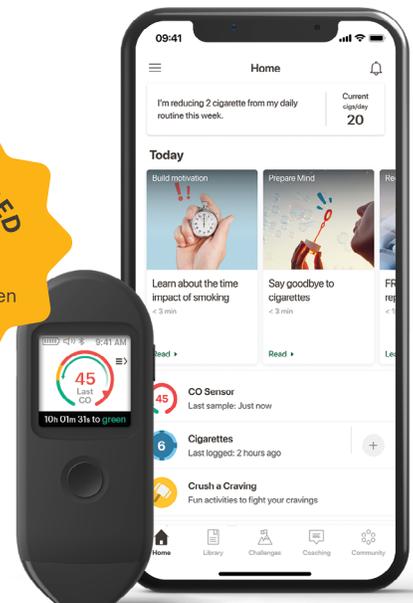
*NRT and the Pivot Sensor are only available to those who smoke cigarettes.

Pivot's SmartSensor*

The only quit smoking program with an FDA-cleared device to help you quit. For the first time, you can measure daily improvements and see the impact of changes you make in real-time. Simply skip a cigarette, or delay your next one, and watch your carbon monoxide levels drop.

Clinically proven to:

- ↑ motivation to quit
- ↓ cigarettes per day



Click or scan the QR code with your phone's camera and visit pivot.co/surest with access code **surest** to learn more.

Do you vape, chew, or smoke cigars?
Pivot can help with that too!

MK-20675 RevA

Surest Member Services:
866-683-6440, Monday – Friday, 6 am – 9 pm CT.

Brought to you by: **surest™**

Getting started

Talkspace is your digital space for private and convenient mental health support. With Talkspace, you can receive counseling, therapy, and medication services from the convenience of your device (iOS, Android, and web).

All care is led by a behavioral health clinician or medical professional. Talkspace's network features thousands of licensed, insured, and verified therapists and specialized prescribers who can support a variety of needs—including, but not limited to:

- ✓ Stress
- ✓ Anxiety
- ✓ Depression
- ✓ Eating disorders
- ✓ Substance use
- ✓ Sleep
- ✓ Identity struggles
- ✓ Chronic issues
- ✓ Trauma & grief
- ✓ Relationships
- ✓ Healthy living
- ✓ ...and more

Counseling and therapy

On average, members can begin communications within days of matching with a licensed provider. Therapists typically engage daily during their business hours. Live sessions can take place within days of scheduling.*

Medication evaluation and management

Find an available psychiatric prescriber in minutes. With Talkspace Psychiatry, you can schedule video appointments with an in-state, licensed provider who specializes in psychiatric evaluation. You'll meet virtually over live video within two weeks of booking (on average).

Additional services

Members have access to Talkspace education and self-help tools to complement your mental health journey. Designed by clinical experts, exercises are interactive, therapeutic, and easy to use.

Meditation

Journaling

Reflections

Positive thinking

**Appointment scheduling is based on availability and preferences*

Ready to get started?

- To register, visit talkspace.com/surest
- Complete our QuickMatch™ provider finder tool to review your best match
- Schedule a live session or message right away

Questions?

Contact Connect-Support@talkspace.com or visit your benefit FAQ page



**Better Choices,
Better Health®**



Better Choices, Better Health is a free 6-week online workshop that helps you take control of your health. Learn to manage long-term health conditions like **diabetes, high blood pressure, heart disease, sleep apnea, depression, arthritis** and others to improve your quality of life.



Learn new practical ways to deal with pain, fatigue and stress.



Get guidance from trained leaders with similar health challenges.



Connect with others just like you. Log in anytime that fits your schedule.

Join our online workshop at bit.ly/SurestBCBH



“I was surprised at how quickly we bonded online . Within the first or second session I felt like we were friends. We all had something in common. It was amazing how supportive we were of each other.”

- Kelle, BCBH Participant

“I may have a chronic condition, but it doesn't have me.”

- Muriel, BCBH Participant



Health Savings Account

An HSA lets you save money for future healthcare costs while also saving on taxes. How? HSAs are the only benefit with a triple-tax advantage:¹ Tax-free contributions. Tax-free account growth. And tax-free spending on HSA-qualified expenses. It's your healthcare emergency safety net.

- ✓ No use-it-or-lose-it rule, HSAs rollover every year
- ✓ Available tax-free investing, just like a 401(k)²
- ✓ Requires an eligible high-deductible health plan (HDHP)



Don't tax your money. Max your money.

Get \$20 tax savings for every \$100 you contribute.³

HSA

Tax-free

No HSA

Taxed

2025 HSA Contribution Limits



\$4,300

Individual plan



\$8,550

Family plan

Members 55+ can contribute an extra \$1,000.

Spend tax-free.

There are thousands of HSA-qualified expenses. Here are just few:

- Medical
- Dental
- Vision
- Pharmacy
- Over-the-counter (OTC) medications
- Mental health services
- Lab fees



See how much
you can save.

HealthEquity.com/Learn/HSA

¹HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules. | ²Investments made available to HSA members are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. | ³Example for illustration only. Estimated savings are based on an assumed combined federal and state income tax bracket of 20%. Actual savings will depend on your taxable income and tax status. HealthEquity does not provide legal, tax or financial advice.

Virtual care that makes healthier possible

Access your healthcare by
phone, video or app.



General Medical (24/7 Care)

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

Expert Medical Opinion

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

Mental Health

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



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

Digital Physical

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

Dermatology

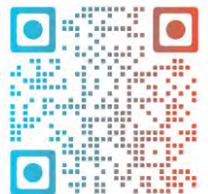
Start an online skin review with a dermatologist by uploading images and details of your concern. Get a treatment plan and prescription if needed in 24 hours or less.

Nutrition

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

Set up your account or log in to schedule a visit

Visit [HealthiestYou.com](https://www.healthiestyou.com) | Call 1-866-703-1259 | Download the app  

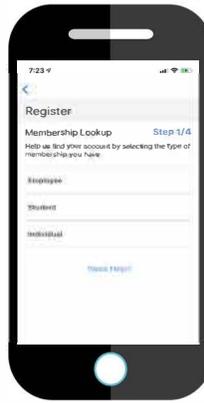


How to register and get started with HealthiestYou!



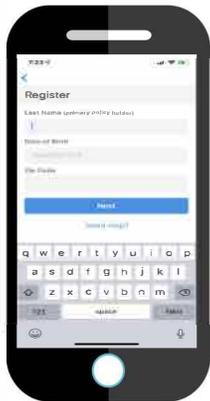
Step 1

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



Step 2

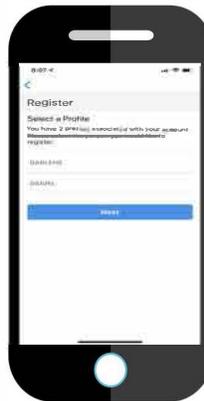
- Select “First time here? Register Now”. Select employee as your membership type.



Step 3

Enter the Primary Member's Information:

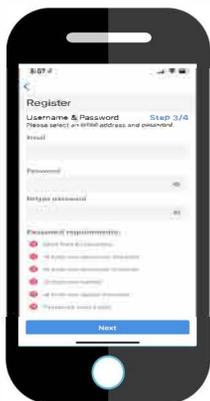
- Last Name
- D.O.B.
- Zip Code



Step 4

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

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



Step 5

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



Step 6

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

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

Download the App Today!

member.healthiestyou.com

Need A Doctor? 866-703-1259 x1

Account Help? 866-703-1259 x3



Links to 'How To' Videos

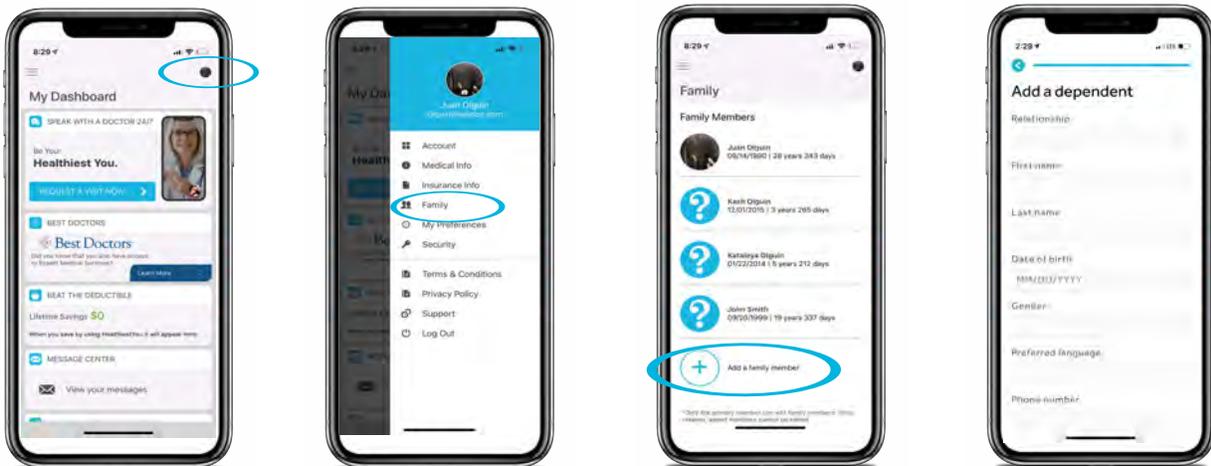
[Adding Family - App](#)

[Adding Family - Website](#)

Adding your Dependents Through the HY mobile app.

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

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



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

Set up your account today

HealthiestYou.com | 866-703-1259

All Full-Time Employees of New Century School

Benefits At-A-Glance

Dental Insurance

The Lincoln DentalConnect® PPO Plan:

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

	In-Network	Out-of-Network
Calendar (Annual) Deductible	Individual: \$25 Family: \$75 Waived for: Preventive	Individual: \$50 Family: \$150 Waived for: Preventive

Deductibles are combined for basic and major In-Network services.
Deductibles are combined for basic and major Out-of-Network services.

Annual Maximum	\$2,000	\$1,500
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Annual Maximums are combined for preventive, basic, and major services.

Lifetime Orthodontic Max	\$2,000	\$1,500
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Orthodontic Coverage is available for dependent children.

Waiting Period	There are no benefit waiting periods for any service types
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Visit LincolnFinancial.com/FindADentist

You can search by:

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

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

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

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

With the Lincoln Dental Mobile App

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

Lincoln DentalConnect® Online Health Center

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

Covered Family Members

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

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

Benefit Exclusions

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

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

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

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

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

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



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Dental Coverage | At-A-Glance

Dental Rate

Here's how little you pay with group rates.

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

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

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

The Lincoln National Life Insurance Company

Please see prior page for product information.

Dental Coverage | Rate Calculation

Vision Plan Summary

Metropolitan Life Insurance Company

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in network.
- Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco[®] Optical, Walmart, Sam's Club³ and Visionworks.

In-network value added features:

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

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

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

In-network benefits

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

	Frequency
Eye exam	Once every 12 months

- Eye health exam, dilation, prescription and refraction for glasses: Covered in full after **\$10** copay.
- Retinal imaging: Up to a **\$39** copay on routine retinal screening when performed by a private practice provider.

	Frequency
Frame	Once every 12 months

- Allowance: **\$150** after **\$10** eyewear copay.
- Costco, Walmart and Sam's Club: **\$85** allowance after **\$10** eyewear copay. You will receive an additional **20%** savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club.

	Frequency
Standard corrective lenses	Once every 12 months

- Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after **\$10** eyewear copay

	Frequency
Standard lens enhancements¹	Once every 12 months

- Polycarbonate (child up to age 18) and Ultraviolet (UV) coating: Covered in full after **\$10** eyewear copay.
- Progressive, Polycarbonate (adult), Photochromic, Anti-reflective, Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at metlife.com/mybenefits.

	Frequency
Contact lenses instead of eye glasses	Once every 12 months

- Contact fitting and evaluation: Covered in full with a maximum copay of **\$60**.
- Elective lenses: **\$150**
- Necessary lenses: Covered in full after eyewear copay.

We're here to help

Find a participating vision specialist:

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

Get a claim form:

www.metlife.com/mybenefits

General questions:

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

Out-of-network reimbursement

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

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

Exclusions and Limitations of Benefits

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

Services and Eyewear

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your Dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or

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

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

3 Vision benefits offered through Walmart and

- committing or attempting to commit a felony.
 - Services and materials obtained while outside the United States, except for emergency vision care.
 - Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
 - Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
 - Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the Group Policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program, or coverage provided by a government as an employer or Medicare.
 - Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter).
 - Two pairs of glasses instead of bifocals.
 - Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen, or damaged (within the 12 month benefit period from date of purchase.)
- Contact lens insurance policies and service agreements.
 - Refitting of contact lenses after the initial (90-day) fitting period.
 - Contact lens modification, polishing, and cleaning.

Treatments

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

Medications

- Prescription and non-prescription medication

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

M150A-10/10

Benefits are underwritten by Metropolitan Life Insurance Company, New York, NY.

Certain claims and network administration services are provided through Vision Service Plan. Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

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



New Century School Benefits At-A-Glance

All Full-Time Employees

Life and AD&D Insurance

Safeguard the most important people in your life.

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

At a glance:

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

Additional details

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

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

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

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

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

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

Monthly Life Insurance Premium Calculate Your Premium.

Here's how little you pay with group rates.

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

Coverage	Monthly Rate
Employee Life and AD&D	\$0.026

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

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

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

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



All Full-Time Employees of New Century School

Benefits At-A-Glance

Voluntary Term Life and AD&D Insurance

The Lincoln Term Life and AD&D Insurance Plan:

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

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

What your benefits cover

Employee Coverage

Guaranteed Life and Optional AD&D Insurance Coverage Amount

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

Maximum Life Insurance Coverage Amount

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

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

Guaranteed Life and Optional AD&D Insurance Coverage Amount

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

Maximum Life Insurance Coverage Amount

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

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

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

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

Additional Plan Benefits

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

Benefit Exclusions

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

For life insurance, a suicide exclusion may apply.

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

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

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

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

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

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. *TravelConnect*® travel assistance services are provided by On Call International, Salem NH. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. ComPsych® and On Call International are not Lincoln Financial Group companies and Lincoln Financial Group does not administer these Services. Each independent company is solely responsible for its own obligations. Coverage is subject to contract language that contains specific terms, conditions, and limitations.

Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.



Monthly Voluntary Life and AD&D Insurance Premium

Here's how little you pay with group rates.

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

Group Rates for You

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

$$\text{\$ } \underline{\hspace{2cm}} \times \underline{\hspace{2cm}} = \text{\$ } \underline{\hspace{2cm}}$$

coverage amount premium factor monthly premium

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

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

Group Rates for Your Spouse

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

$$\text{\$ } \underline{\hspace{2cm}} \times \underline{\hspace{2cm}} = \text{\$ } \underline{\hspace{2cm}}$$

coverage amount premium factor monthly premium

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

The Lincoln National Life Insurance Company
Please see prior page for product information.

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

Dependent Children Monthly Premium for Life Insurance Coverage

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

Group Rates for Your Dependent Children

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

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

The Lincoln National Life Insurance Company
Please see prior page for product information.

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



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

All Full-Time Employees

Short-term Disability Insurance

Protect your paycheck when you can't work.

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

AT A GLANCE:

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

ADDITIONAL DETAILS

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

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

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

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

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

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

Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations. Limitations and exclusions apply.



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

All Full-Time Employees

Long-term Disability Insurance

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

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

AT A GLANCE:

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

ADDITIONAL DETAILS

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

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

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

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

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

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Delivering
affordable eye
care for you
and your family



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

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

Your vision discounts

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

- Discounts** through a trusted network of eye doctors
- \$50** for an eye exam¹
- 15% savings** on a contact lens exam²
- Special pricing** on complete pairs of glasses and sunglasses
- Reduced pricing** on laser vision correction through contracted facilities

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

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

Lincoln VisionConnect[®]
discount vision program



Name _____

Discount program only. Not an insurance program.



Save on vision care today

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

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





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

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

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



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

 <p>In-person guidance</p>	 <p>Unlimited 24/7 assistance</p>	 <p>Online resources</p>
<p>Some matters are best resolved by meeting with a professional in person. With <i>EmployeeConnect</i>, you and your family get:</p> <ul style="list-style-type: none"> ▪ In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year) ▪ In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings 	<p>You and your family can access the following services any time – online, on the mobile app, or with a toll-free call:</p> <ul style="list-style-type: none"> ▪ Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more ▪ Legal information and referrals for family law, estate planning, and consumer and civil law ▪ Financial guidance on household budgeting and short- and long-term planning 	<p><i>EmployeeConnect</i> offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the GuidanceNowSM mobile app. You'll find:</p> <ul style="list-style-type: none"> ▪ Articles and tutorials ▪ Videos ▪ Interactive tools, including financial calculators, budgeting worksheets, and more

***EmployeeConnect*SM**
EMPLOYEE ASSISTANCE PROGRAM SERVICES
 Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

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

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



EmployeeConnect counselors are experienced and credentialed.

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

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



Take advantage of *EmployeeConnect*

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

GuidanceResources.com login credentials:

Username: LFGSupport Password: LFGSupport1

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LCN-2836182-112019

MAP 9/21 Z03

Order code: LTD-EAPEE-FLI001



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*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

To find out more:

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



Lincoln VisionConnect[®] and EPIC Hearing Service Plan

Enjoy discounted rates on vision and hearing care



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



See the savings

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

- **Discounts** through a trusted network of eye doctors
- **One rate of \$50** for an eye exam¹
- **15% savings** on a contact lens exam²
- **Special pricing** on complete pairs of eyeglasses and sunglasses
- **Reduced pricing** on laser vision correction through contracted providers



Hear the difference

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

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

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

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

Lincoln VisionConnect
discount vision program



Name _____

Discount program only. Not an insurance program.



Save today

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

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

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



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The *Lincoln VisionConnect*[®] discount vision program is provided by VSP Vision Savings Pass. The discount program is not a qualified health plan under the Affordable Care Act. The *Lincoln VisionConnect*[®] discount vision program is NOT insurance. The discount program provides discounts at certain healthcare providers for services. The range of discounts will vary depending on the type of provider and service. Plan members are obligated to pay for all healthcare services but will receive a discount from those healthcare providers who have agreed to provide discounts. The plan and its administrators have no liability for providing or guaranteeing service by providers or the quality of service rendered by providers. The VSP Vision Savings Pass does not take precedence over any other VSP coverage and cannot be combined with other VSP coverage. This plan is not available to members in Washington or to members with an employer located in Washington. VSP Vision Service Plan, Inc. is located at 3333 Quality Drive, Rancho Cordova, CA 95670.

VSP and WellVision[®] Exam are registered trademarks of Vision Service Plan. Hearing services are provided by EPIC Hearing Health Care. This service is not available to members with an employer located in Washington. EPIC Hearing Health Care is not a Lincoln Financial Group[®] company. This service is not available to members with an employer located in Washington. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations.

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

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

Because life
doesn't always
go as planned.



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

LifeKeys services include:



Discounts on shopping and entertainment

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



Help with important life matters

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



Protection against identity theft

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



Online will preparation

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



Guidance and support for your beneficiaries

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

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

Help, guidance, and support for beneficiaries following a loss

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

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

Grief counseling — advice, information, and referrals on:

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

Legal support — access to legal information on:

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

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

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

Help with everyday life — comprehensive information on:

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



Access *LifeKeys* services. Visit [GuidanceResources.com](https://www.GuidanceResources.com), download the *GuidanceNow* mobile app, or call 855-891-3684. First-time users: enter web ID: *LifeKeys*.

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LCN-3985132-121521

MAP 1/22 **Z04**

Order code: LFE-LKEYE-FLI001



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



Lincoln FuneralPrep: Help when you need it most

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

What is Lincoln FuneralPrep?

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



At-need planning

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



Pre-planning

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

How to access Lincoln FuneralPrep

You can access Lincoln FuneralPrep in two ways.

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

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



Search for funeral homes

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



Access market information

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



View guides and checklists

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

2 Connect with a funeral planning consultant

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



Help compare options

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



Provide personalized service

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



Offer objective guidance

Get guidance on planning options and various funding strategies.

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LCN-3795167-092721

ADA 1/23 **Z08**

Order code: **LFE-FNPRP-FLI001**



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

To learn more, visit LincolnFuneralPrep.com/GPLife.



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

Not available in New York.

Caring support and assistance when you travel



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

Services you can count on during an emergency

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

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

Ongoing support when you're far from home

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

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

***TravelConnect*[®]**

GLOBAL ASSISTANCE PROGRAM

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



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





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

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

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

Not available in New York and Washington.

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LCN-3885715-102621

MAP 12/21 **Z03**

Order code: LFE-TRVFE-FLI001



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

Call collect from anywhere in the world:

603-328-1955

Call toll free from U.S. or Canada:

866-525-1955

Email: mail@OnCallInternational.com

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

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



On Call International

A member of the Tokio Marine HCC group of companies

MetLaw[®]

Smart. Simple. Affordable.[®]

Telephone & Office Consultations

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

Legal Representation

Estate Planning

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

Money Matters

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

Real Estate Matters

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

Elder Law Matters

Consultation & Document Review for issues related to your parents:

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

Family Law

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

Traffic Offenses*

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

Document Preparation

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

Immigration Assistance

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

Juvenile Matters

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

Consumer Protection

- Disputes over Consumer Goods & Services
- Small Claims Assistance

Defense of Civil Lawsuits

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

Personal Property Protection

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

For More Information:

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

\$19.50 per month

covers employee, spouse and dependents

The cost is automatically deducted from your paycheck.

Additional Plan Features

Reduced Fees

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

Family Matters^{™**}

Available for an additional fee. Separate plan for parents of participants for estate planning documents.

E-Services

Attorney Locator; Law Firm E-Panel[®]; Free, downloadable legal documents; Life Guide; Links to financial planning, insurance & work/life matters resources

Smart. Simple. Affordable.[®]

Hyatt Legal Plans

A MetLife Company



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SPECIAL NOTICES

PLAN YEAR: 2025

CONTACT INFORMATION

PLAN ADMINISTRATOR	
Contact Name:	Deema Sorri
Phone Number:	651-478-4535
E-mail:	business@newcenturyschool.net
HEALTH INSURANCE PROVIDER	
Health Insurer:	UnitedHealthCare
Customer Service:	866-414-1959
Website:	www.uhc.com
PRIVACY OFFICER	
Contact Name:	Ahmed Ali
Business Address:	1380 Energy Lane, Suite 108
	St. Paul, MN 55108
Phone Number:	651-478-4535
E-mail:	ahmed.ali@newcenturyschool.net
Website:	www.newcenturyschool.net
MEDICARE PART D	
Creditable:	C5000 Surest Plan
Creditable:	\$2,000-100% HSA

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

WHCRA ENROLLMENT NOTICE

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

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

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

SPECIAL ENROLLMENT NOTICE

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

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

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

NEWBORN'S ACT DISCLOSURE

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

General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

How Can I Get More Information?

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

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

YOUR INFORMATION, YOUR RIGHTS, OUR RESPONSIBILITIES

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

Your Rights

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

Get a copy of your health and claims record	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• You can ask us to correct your health and claims records if you think they are correct or incomplete. Ask us how to do this.• We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communication	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• You can ask us not to use or share certain health information for treatment, payment, or our operations.• We are not required to agree to your request, and we may say “no” if it would affect your care.
Get a list of these with whom we’ve shared information	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• You can complain if you feel we have violated your rights by contacting us using the Privacy Officer contact information.• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:	<ul style="list-style-type: none">• Share information with your family, close friends, or other involved in payment for your care• Share information in a disaster relief situations• Contact you for fundraising efforts• If you are not able to tell us your preference, for example if you are unconscious we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• We can use and disclose your information to run our organization and contract you when necessary.• We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	Example: We use health information about you to develop better services for you.
Pay for your health services	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• We may disclose your health information to your health plan sponsor for plan administration.	Example: Your company contacts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

Help with public health and safety issues	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • We can use or share your information for health research
Comply with the law	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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/oct/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

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

GINA DISCLOSURE

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

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

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

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

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

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

MENTAL HEALTH & ADDICTION EQUITY ACT DISCLOSURE

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

ADA WELLNESS PROGRAM NOTICE

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

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

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

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

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

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

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

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

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

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

Wellness Program Disclosure

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfir/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofa/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfnv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

Emergency services

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

[Insert plain languagesummary of any applicable state balance billing laws or requirements OR state-developed language as appropriate]

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

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

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

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

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

[Insert plain languagesummary of any applicable state balance billing laws or requirements OR state-developed language regarding applicable state law requirements as appropriate]

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

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

- The US Department of Health and Human Services at:
Phone: 800-985-3059
Website: <https://www.cms.gov/nosurprises/consumers>
- Your state agency, which can be found at:
<https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants>

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE CREDITABLE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. We have determined that the prescription drug coverage offered by the company is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare 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 coverage will not be affected. Please see the Insurance Carrier for additional information regarding plan coverage
- If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will may not be able to get this coverage back.

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

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

For more information about this notice or your current prescription drug coverage...

Contact the person listed as the plan administrator for further information NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

- More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
- For more information about Medicare prescription drug coverage: Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

GLOSSARY

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

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

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

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

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

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

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

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

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

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

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

Covered Person - Any person covered under the plan.

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

Creditable Coverage - Coverage of a person under any of these:

A group health plan. This includes church and governmental plans.

Health insurance coverage.

Medicare (Part A or Part B of Title XVIII of the Social Security Act).

Medicaid (Title XIX of the Social Security Act, other than coverage consisting only of benefits under Section 1928).

The health plan for active military personnel. This includes TRICARE.

The Indian Health Service or other tribal organization program.

A state health benefits risk pool.

The Federal Employees Health Benefits Program.

A public health plan (as defined in federal regulations).

A health benefit plan under section 5 (c) of the Peace Corps Act.

Any other plan which gives complete hospital, medical and surgical services.

Deductible - The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time). *Example: If your plan has a \$2,000 annual deductible, you will be expected to pay the first \$2,000 toward your healthcare services.*

Dependent Coverage - Coverage for your dependents who qualify.

Emergency Medical Condition - A medical problem with sudden and severe symptoms that must be treated quickly. In an emergency, a person with no medical training and an average knowledge of health/medicine could reasonably expect the problem could:

Put a person's health at serious risk.

Put an unborn child's health at serious risk.

Result in serious damage to the person's body and how his or her body works.

Result in serious damage to a person's organ or any part of the person.

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

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

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

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

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

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

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

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

Medically Necessary (or Medical Necessity) - Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:

Accepted as standard practice. It can't be experimental or investigational.

Not just for your convenience or the convenience of a provider.

The right amount or level of service that can be given to you.

Example: Inpatient care is medically necessary if your condition can't be treated properly as an outpatient service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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