2024 - 2025

Employee BENEFITS GUIDE

uplifteducation

CONTACT INFORMATION

DIRECTORY

For any questions or concerns you may have regarding your 2024-2025 Employee Benefits, you can contact the following:

- For claims assistance, you can contact the insurance carrier. You will need your ID number or Social Security number, date of service and provider name.
- For additional assistance or questions, please contact one of our Benefit Counselors at the Benefits Service Center.

Before you speak with a Benefit Counselor, please have the following information ready: dependents' names, birth dates, social security numbers, addresses, and phone numbers.

Benefits Service Center *(*Consejeros que hablan español están disponibles.)*

Monday - Friday: 8:00 am - 7:00 pm CST
Saturday: 9:00 am - 3:00 pm CST

(866) 409-3174
www.upliftedcationbenefits.org

Benefit/Carrier	Policy/ Group #	Telephone/ Website or Email	Where to File Claims
Medical BCBSTX PPO High Deductible HMO Low Deductible HMO High Deductible PPO Grandfathered (Closed)	368172 368173 368175 368171	(800) 521-2227 - PPO (877) 299-2377 - HMO *www.bcbstx.com*	*Online - Blue Access for Members (registration required)* *BCBSTX Medical Claim Form - Domestic (English)* *BCBSTX Medical Claim Form - Domestic (Spanish)* *BCBSTX Prescription Drug Claim Form (English)* *BCBSTX Prescription Drug Claim Form (Spanish)*
Emergency Medical Transportation MASA	N/A	(877) 503-0585 *www.masaaccess.com*	
Health Savings Account **Flexible Spending Accounts** CAS	N/A	(877) 941-5956 *www.consolidatedadmin.com*	*Online – CAS Website (registration required)* *Medical Claim Form* *Dependent Care Claim Form*
Dental BCBSTX Low Plan High Plan	368177 368176	(800) 521-2227 *www.bcbstx.com*	*Online - Blue Access for Members (registration required)* *Dental Claim Form*
Vision BCBSTX	VF028267	(855) 556-8796 *member.eyemedvisioncare.com/bcbstx/en*	*Online - EyeMed Vision Care (registration required)* *Vision Claim Form*
Short Term Disability **Long Term Disability** **Basic Life and AD&D** **Voluntary Life and AD&D** Dearborn Life	VF028267	(877) 442-4207 *www.bcbstx.com/ancillary* *ancillaryquestionstx@bcbstx.com*	*Online – BCBSTX Ancillary Benefits Website* *Long-Term Disability Claim Form* *Long-Term Disability Claim Form Spanish* *Short-Term Disability Claim Form* *Short-Term Disability Claim Form -Spanish* *Accidental Death & Dismemberment Claim Form* *Life Insurance Claim Form* *Life Insurance Claim Form- Spanish*
Universal Life Transamerica Life Insurance	G000046991	(800) 797-2643 *www.transamerica.com*	*Online - Transamerica Universal Life (Registration required)* *Death Claim Form*
Accident **Critical Illness** **Cancer Insurance** **Hospital Indemnity** Guardian	551834	(800) 268-2525 *www.guardiananytime.com*	
403(b) Retirement Benefit TCG Group Holdings	N/A	(800) 943-9179 *www.region10rams.org* *403b@tcgservices.com*	N/A
Employee Assistance Program ComPsych/GuidanceResources	U: TBD P: TBD	(888) 628-4824 *www.guidanceresources.com*	*Online – CompPsych GuidanceResources* Registration required (**Company Code: DISRES**) **Search:** Out of Network Claims Submission
Pet Insurance Nationwide	N/A	(877) 738-7874 *www.benefits.petinsurance.com/upliftedcation*	
Uplift Talent Management Uplift Education	N/A	***iHelp Tickets***	N/A

WELCOME

To Your Employee Benefits

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Each year, we strive to offer comprehensive and competitive benefit plans to our employees. In the following pages, you will find a summary of our benefit plans for the **September 1, 2024 to August 31, 2025** Plan Year. Please read this Benefits Guidebook carefully as you prepare to make your elections for the upcoming Plan Year.

Uplift Education will be utilizing Professional Enrollment Concepts' (PEC) services for our benefit communication and enrollment this year. PEC's Benefit Counselors will provide you with a detailed explanation of your entire benefit program. They will review your benefits with you on an individual, confidential basis. They will also be able to discuss any personal situations you may have that could potentially impact your benefit decision.

ABOUT THIS BENEFITS GUIDEBOOK

This Benefits Guidebook describes the highlights of Uplift Education's benefits program in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents, and not the information in this Benefits Guidebook. If there is any discrepancy between the description of the program elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. You should be aware that any and all elements of Uplift Education's benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules, or otherwise as decided by Uplift Education.

WHAT'S NEW THIS 2024-2025 YEAR?

- The annual contribution limit for **Health Savings Accounts** increased from $3,850 to $4,150 per plan year for employees enrolled in Employee Only medical coverage and from $7,750 to $8,300 per plan year for employees enrolled Employee & Children, Spouse, or Family coverage.
- The annual contribution limit for the **Health Care FSA** plan increased from $3,050 to $3,200 per plan year.
- **MASA emergency medical transportation** plans available for 2024-2025 through payroll deduction. See page 14 for details.
- **Pet Insurance** available through payroll deduction offered by Nationwide. See page 36 for details.

ELIGIBILITY

			Benefits Eligibility Based on Weekly Hours Worked		
Benefits	Provider	Effective Date	Full-Time (30+) Permanent Subs	Part-Time	Substitutes
Medical	Blue Cross Blue Shield of Texas	1st of the month following date of hire	*	* but not eligible for Cafeteria Credit	* but not eligible for Cafeteria Credit
Medical Transportation	MASA	1st of the month following date of hire	*	*	
Dental	Blue Cross Blue Shield of Texas	1st of the month following date of hire	*		
Vision	Blue Cross Blue Shield of Texas	1st of the month following date of hire	*		
Basic Life & AD&D	Dearborn National	1st of the month following date of hire	*		
Supplemental Life	Dearborn National	1st of the month following date of hire	*		
LongTerm Disability	Dearborn National	1st of the month following date of hire	*		
Short-Term Disability	Dearborn National	1st of the month following date of hire	*		
Universal Life	TransAmerica Life Insurance Company	1st of the month following date of hire	*		
Dependent Care FSA Health FSA Health Savings Account	Consolidated Admin Services (CAS)	1st of the month following date of hire	*	*	
Accident Insurance Cancer Insurance Critical Illness Insurance Hospital Indemnity Insurance	The Guardian Life Insurance Company	1st of the month following date of hire	*		
Pet Insurance	Nationwide	1st of the month following enrollment date	*	*	
403(b) Retirement Savings	TCG Group Holdings	1st of the month following enrollment on TCG website	*		
Employee Assistance Programs	Guidance Resources/ComPsych	1st of the month following date of hire	*	*	

When you're enrolled in a medical insurance plan through Uplift Education, we will contribute a cafeteria credit - which is an employer subsidy - toward your monthly medical insurance premium.

If you choose to waive or decline medical insurance, Uplift Education will provide a monthly cafeteria credit of up to $250 for Dental, Vision, and/or Short-Term Disability premiums. However, if you previously declined dental, vision, or the short-term disability plan, you won't be able to add these coverages when waiving the medical plan.

PART-TIME EMPLOYEES

Employees working at least 10 hours but less than 30 hours per week, are eligible for medical insurance, pet insurance, and MASA medical transportation benefits. Part-Time employees do not qualify for the Uplift Education monthly cafeteria credit.

EMPLOYEE ELIGIBILITY

New Hires have 30 days from their hire date to enroll in or decline benefits. All benefits are effective the first of the month following your hire date.

Ancillary Benefits:

- Accident Insurance
- Critical Illness Insurance
- Cancer Insurance
- Dental Insurance
- Hospital Indemnity Insurance
- Short-Term Disability Insurance
- Supplemental Life Insurance
- Universal Life Insurance
- Vision Insurance
- Long-Term Disability Insurance
- MASA Medical Transportation
- Pet Insurance

DEPENDENT ELIGIBILITY

If you apply for coverage, you may include your dependents. All employees must ensure that only family members who meet the following requirements are enrolled in the Uplift insurance and healthcare benefits programs. Uplift Education may conduct an audit requesting supporting documentation on all eligible dependents at any time during the plan year. Eligible dependents include one or more of the following:

- Your spouse;
- A child under the age of 26;
- A child of any age who is certified as disabled and dependent on the parent for support and maintenance.

ENROLLMENT INSTRUCTIONS

HOW TO ENROLL

**Avoid making quick decisions - enroll early!*

This year you have two enrollment options. You can contact our Benefit Counselors at the Benefits Service Center or utilize our online self-service platform to explore your options further and complete your benefits enrollment process.

To complete your enrollment process, please have the following information ready: dependents' names, birth dates, social security numbers, addresses, and phone numbers.

Call Center Enrollment

Benefits Service Center*: (866) 409-3174
Monday - Friday: *8:00 AM - 7:00 PM (CST)*
Saturday: *9:00 AM - 3:00 PM (CST)*

**Consejeros que hablan español están disponibles.*

Online Enrollment

Online Enrollment Website:
transamerica.benselect.com/enroll

For online enrollment, use the following format as login information:

Employee ID or SSN: Your SSN with no formatting (#########)
PIN: Last 4 digits of your SSN and the last 2 digits of your birth year (######)

Example:
John Smith | **SSN:** 123-45-6789 | **DOB:** 01-27-1993
Employee ID or SSN: 123456789
PIN: 678993

Visit page 6 for more detailed self-serve instructions.

2024 OPEN ENROLLMENT

Enrollment is strongly encouraged, whether you choose to elect or waive coverage. Remember you must enroll each year in your Flexible Spending Account.

OE runs from **July 8, 2024 - July 29, 2024**.

BENEFITS EFFECTIVE DATE

Generally, you cannot make any changes to your benefits during the year, unless you experience a Qualifying Life Event (QLE).

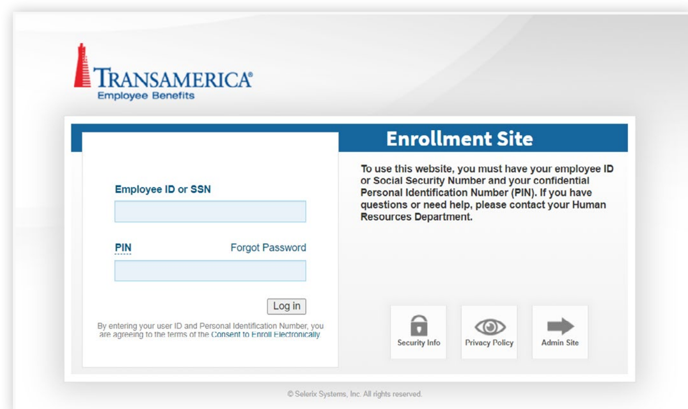
- New Hires: Your coverage begins the first of the month following your date of hire.
- Current Employees: Any changes you make during the annual open enrollment period will become effective on September 1.

The benefits plan year is September 1 through August 31.

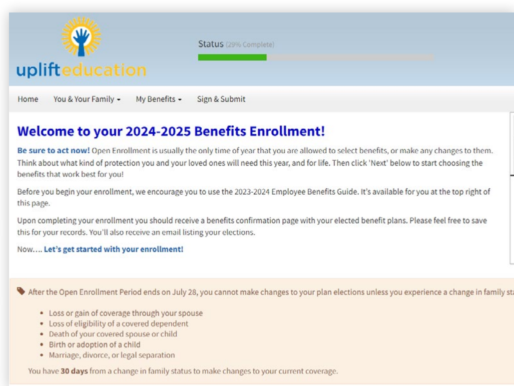
SELF-SERVICE INSTRUCTIONS

- ☐ Register for the portal by logging on to: transamerica.benselect.com/enroll

  Employee ID or SSN: Your SSN with no formatting (#########)
  PIN: Last 4 digits of your SSN and the last 2 digits of your birth year (######)



- ☐ Review the Welcome screen for important plan information. When ready ***click Next*** to continue.
- ☐ Next, you will be asked to enter dependent information. To add a dependent, ***click the + sign*** and enter the dependent's information. To edit an existing dependent, ***click the pencil icon*** on the right side of the dependent. After making any changes, ***click save*** on the bottom of the page. Once you are finished with this section, ***click next***.
- ☐ Once you are at the medical screen, verify your medical plan election or waive the coverage. When you ***click next***, you will advance to any coverage that you have not previously enrolled in.
- ☐ Once you are at the medical screen, verify your medical plan election or decline the coverage. When you ***click next***, you will advance to any coverage that you have not previously enrolled in.



- ☐ If you would like to make changes to existing coverage, you may click on the individual coverage options listed under ***"My Benefits"*** or by choosing the coverage under the ***"My Benefits" menu*** at the top of the screen.
- ☐ Once you select the coverage you would like to change, click on ***"Unlock"*** to access the options. Once you make a decision, ***click next*** to go to the review page.
- ☐ Once on the ***"Sign and Submit"*** page, you will be able to review your elections. If you need to make changes, click on the link for that coverage. You will then unlock, make your change, and ***click next***. This returns you to the ***"Sign and Submit"*** page. If everything is correct, ***click next***.
- ☐ On the ***"Confirmation"*** page, enter your PIN / Password used to log in. ***This will finalize your enrollment.*** You can print the confirmation form, save it as a downloadable PDF, and e-mail a confirmation summary to the e-mail address on file.

If you have any additional questions regarding your benefits, please call:

Benefits Service Center: (866) 409-3174
Monday - Friday: 8:00 AM - 7:00 PM CST
Saturday: 9:00 AM - 3:00 PM CST

NEW HIRE CHECKLIST

Welcome to the Uplift Family! We are honored to offer a competitive benefits package designed to meet the needs of you and your family. You have thirty days from your date of hire (printed on your offer letter) to complete your New Hire Enrollment elections.

Whether this is your first time accepting benefits from an employer or your 10th, there are many things to consider prior to and after enrollment. We have created the following checklist of tasks to guide you through the enrollment process.

Within 30 days from your date of hire:

- ☐ **Review the Benefits Guidebook & Benefits Website.** Plan and eligibility details, premium information, required notices and disclosures, useful reference material are provided within our Benefits Guide. The benefits website houses indepth plan descriptions/documents, and useful links to carrier resources. It is important that you review all documents related to any plan that you intend to enroll in. Click the link to access the Benefits Website: http://upliftedcationbenefits.org/.
- ☐ **Evaluate any in-force insurance policies.** If you are currently enrolled in coverage outside of Uplift, it may benefit you to compare your current plan documents to the plan documents for Uplift's coverage. Our benefit counselors are equipped to help you verify that your benefits package compliments the coverage that your family currently has in place.
- ☐ **Ask questions.** If you have questions about any of the material that you have reviewed, you may contact the Benefits Service Center at (866) 409-3174.
- ☐ **Gather dependent and beneficiary information.** You will be required to provide the name, date of birth, SSN, and address for any dependents you enroll in coverage. It is also vital that you provide accurate contact information for your beneficiaries.
- ☐ **Visit the Benefits Enrollment website or call the Benefits Service Center at (866) 409-3174 for questions to process your enrollment. You have two options for enrollment:**
  - You may enroll online using the https://transamerica.benselect.com/enroll. (In addition to enrolling in benefits, you may add/update dependent and beneficiary, access enrollment confirmations, insurance applications and other important plan documents.)
  - You may contact the Benefits Service Center via telephone.

    Benefits Service Center
    Phone: (866) 409-3174
    Hours: M-F 8:00 am - 7:00 pm | Sat 9:00 am - 3:00 pm cst
- ☐ **Carefully review your elections in Selerix.** Make any corrections or contact the Benefits Service Center for assistance.
  - Proper address and contact information
  - Appropriate coverage, costs, and effective dates
  - Updated dependent and beneficiary information
- ☐ **Plan for the financial impact.** Updates to your deductions will be processed within 1-2 pay cycles. Double deductions to assess missed premiums may be required. You may review the Payroll Calendar to determine when your deduction changes will be processed.
- ☐ **Review your paycheck stub(s).** Premiums for the current month are paid on the last day of the month for salaried employees, and on the 15th and the last day of the month for hourly employees. Ensure that any required adjustments to your pay appear as you expected, and immediately notify Talent Management of any discrepancies.
- ☐ **Watch for/Print new ID cards.** Carrier updates will be processed within 5 business days from the date your enrollment is processed. You may print ID cards online no sooner than 10 business days after completing your enrollment. If you make changes that require new ID cards, the medical provider will issue new medical/Rx cards within 14 business days.

Please do not hesitate to reach out to PEC or your Talent Management department with any questions/concerns. It is our pleasure to assist!

QLE CHECKLIST

A Qualifying Life Event (QLE) is a change in your situation — like getting married, having a baby, or losing health coverage — that can make you eligible for a Special 30-Day Enrollment Period, allowing you to enroll in or change your health insurance outside the yearly Open Enrollment Period.

Qualifying life events include:

- A change in the number of dependents (birth, adoption, death, guardianship);
- A change in marital status (marriage, divorce, death, legal separation);
- A dependent's loss of eligibility (attainment of limiting age or change in student status);
- A change in associate's, spouse's, or dependents' work hours;
- A termination or commencement of employment of associate's spouse or eligible dependent with coverage;
- An entitlement to Medicare or Medicaid;
- Other events as the administrator determines to be permitted or any other applicable guidelines issued by the Internal Revenue Service.

An employee must ensure the change in coverage is consistent with the status change. For example, if the employee gets married, he/she has 30 calendar days to enroll the new spouse or drop coverage if the employee will be added to the spouse's plan.

Due to Texas Senate Bill 51 guidelines, medical termination requests may be processed the first of the month following the date in which the Life Event is entered. This may result in a modification to your medical termination and medical effective change dates.

If you have experienced a Qualifying Life Event and wish to update your benefits enrollment, you are required to complete the following task within 30 days:

- [ ] **Please complete an iHelp ticket for QLE changes by emailing people@uplifteducation.org**

After your change has been processed:

- [ ] **Review your confirmation.** Carefully review the changes and immediately advise PEC of any discrepancies.
    - Proper address and contact information
    - Appropriate coverage, costs, and effective dates
    - Updated dependent and beneficiary information
- [ ] **Plan for the financial impact.** Updates to your deductions will be processed within 1-2 pay cycles. Double deductions to assess missed premiums may be required. You may review the Payroll Calendar to determine when your deduction changes will be processed.
- [ ] **Review your paycheck stub(s).** Premiums for the current month are paid on the last day of the month for salaried employees and on the 15th and the last day of the month for hourly employees. Ensure that any required adjustments to your pay appear as you expected and immediately notify Talent Management discrepancies.
- [ ] **Watch for/Print new ID cards.** Carrier updates will be processed within 5 business days from the date your enrollment is processed. You may print ID cards online no sooner than 10 business days after completing your enrollment. If you make changes that require new ID cards, the medical provider will issue new medical/Rx cards within 14 business days.

Please do not hesitate to reach out to PEC or your Talent Management department with any questions/concerns. It is our pleasure to assist!

MEDICAL

BCBSTX

The medical program, administered by BlueCross BlueShield of Texas (BCBSTX), provides the framework for your good health and well-being. In order to better meet the varying needs of our employees, Uplift is offering four medical plans described below.

Highlights	HMO High Deductible	PPO High Deductible (HSA elig.)		HMO Low Deductible	PPO Grandfathered (AC2 Frozen)	
Network Name	*Blue Essentials*	*Blue Choice*		*Blue Essentials*	*Blue Choice*	
Network Type	*In-Network*	*In-Network*	*Out-of-Network*	*In-Network*	*In-Network*	*Out-of-Network*
Plan Year Deductible Individual Family	 $2,500 $5,000	 $3,200 $6,000	 $5,500 $11,000	 $1,200 $3,600	 $1,000 $3,000	 $2,000 $6,000
Out of Pocket Maximum Individual Family	 $8,150 $16,300	 $7,050 $14,100	 $20,250 $40,500	 $6,900 $13,800	 $7,900 $15,800	 $23,700 $47,400
Coinsurance	70%	70%	50%	80%	80%	60%
Office Visits Preventative Services Primary Care Specialist Urgent Care	 No charge $30 copay $70 copay $50 copay	 No charge 70% after ded. 70% after ded. 70% after ded.	50% after ded.	 No charge $30 copay $70 copay $50 copay	 No charge $30 copay $70 copay $50 copay	60% after ded.
MDLive Copay	N/A	$45 after ded.	N/A	N/A	$30 copay	N/A
24/7 Nurseline**	Free	Free	N/A	Free	Free	N/A
Inpatient	70% after ded.	70% after ded.	50% after ded.	80% after ded.	$150 + 80% after ded.	60% after ded.
Outpatient	70% after ded.	70% after ded.	50% after ded.	80% after ded.	80% after ded.	60% after ded.
Emergency Room	70% after ded.	70% after ded.		80% after ded.	$250 copay + 80% after ded.	
Prescription Copays*** *Retail (30-day)* Generic Formulary Brand Formulary Non Formulary Specialty *Mail (90-day)* Generic Formulary Brand Formulary Non Formulary	*Deductible Incl. in Medical* $15 copay* 70% after ded. 50% after ded. 70% after ded. $45 copay 70% after ded. 50% after ded.	*Deductible Incl. in Medical* 80% after ded.* 75% after ded. 50% after ded. 80% after ded. 80% after ded. 75% after ded. 50% after ded.		*$200 Brand ded.* $15 copay* 75% after ded. 50% after ded. 70% after ded. $45 copay 75% after ded. 50% after ded.	*$200 Brand ded.* $20 copay* 75% after ded. ($80 max) 50% after ded. ($200 max) 80% after ded. ($900 max) $45 copay 75% after ded. ($210 max) 50% after ded. ($430 max)	

**$0 for certain generics*
***Medical questions only, do not use for treatment.*
**** Prescription Benefits listed are In-Network Benefits. Visit the [BCBS Pharmacy Benefits] page for pricing and information.*
ded. = deductible

Medical Deductions	Monthly Premiums			
	HMO High Deductible	*PPO High Deductible (HSA elig.)*	*HMO Low Deductible*	*PPO Grandfathered (AC2 Frozen)*
Employee	$24.62	$36.62	$129.78	$628.52
Employee + Spouse	$671.74	$701.78	$773.88	$1,918.60
Employee + Child(ren)	$252.12	$271.14	$343.24	$1,022.26
Family	$899.08	$934.14	$1,099.38	$2,358.26

PRESCRIPTION

BCBSTX

HELPFUL LINKS AND CONTACTS

- BCBS Member Website - *www.bcbstx.com/*
- BCBSTX Virtual Medicine Cabinet – *MyBlueRxTX*
- Manage medications online with *MyPrime.com*
- *Accredo Mail Order Specialty Pharmacy*
  - Refills & Orders: 1-800-803-2523
- Copay Assistance Program: 1-844-682-5152

PRESCRIPTION DISCOUNT PROGRAMS

Below are available programs that may provide discounted pricing and coupons for your prescriptions.

- *MedsYourWay* | BCBSTX Rx Discount Card
- *Capital Rx Advantage | Save Up to 90% on RX*
- *CostPlus Drug Company*
- *GoodRx*
- *Novo Nordisk - Ozempic Coupon Card*
- *Rx Saver*
- *SingleCare*
- *Accredo CoPay Assistance Support*
  - Phone: 844-682-5152

Deductible

The amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying.

Out of Pocket Max

The most money you will pay during a year for coverage (including deductibles, copays, and coinsurance).

Coinsurance

The amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage.

BlueCross BlueShield of Texas

Virtual Visits: Get Cost-Effective, 24/7 Care

With Virtual Visits from MDLIVE®, the doctor is always in. This Blue Cross and Blue Shield of Texas (BCBSTX) benefit gives you access to 24/7 non-emergency care from a board-certified doctor or therapist by phone, online video or mobile app from almost anywhere.

Skip expensive ER bills and waiting to see a doctor. You can speak with a Virtual Visits doctor within minutes.

Services are available in both English and Spanish with translation services available in other languages.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Powered by MDLIVE

Why Virtual Visits?

- 24/7 access to an independently contracted, board-certified doctor or therapist
- Access via phone, online video or mobile app from almost anywhere
- Average wait time of less than 20 minutes
- Doctors can send e-prescriptions to your local pharmacy

The Virtual Visits benefit is a convenient alternative for treatment of more than 80 health conditions, including:

- Allergies
- Cold/Flu
- Fever
- Headaches
- Nausea
- Sinus infections

Virtual Visits sessions with licensed behavioral health therapists are available by appointment. Get virtual care for:

- Depression
- Eating disorders
- ADHD
- Substance use disorders
- Trauma and PTSD
- Autism spectrum disorder

First, call your doctor's office; they may also offer telehealth consultations by phone or online video. If you have any questions about this or any other BCBSTX benefit, please call the number on the back of your ID card.

Activate your Virtual Visits account today:

- Call 888-680-8646
- Go to MDLIVE.com/bcbstx
- Text BCBSTX to 635-483
- Download the app

Virtual Visits may be limited by plan. For providers licensed in New Mexico and the District of Columbia, Urgent Care service is limited to interactive online video; Behavioral Health service requires video for the initial visit but may use video or audio for follow-up visits, based on the provider's clinical judgment. Behavioral Health is not available on all plans.

MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Blue Cross® , Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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24/7 Nurseline

Nurses available anytime you need them.

Health happens – good or bad, 24 hours a day, seven days a week. That is why we have registered nurses waiting to talk to you whenever you call our 24/7 Nurseline.

Our nurses can answer your health questions and try to help you decide whether you should go to the emergency room or urgent care center or make an appointment with your doctor. You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions about:

- Asthma
- Dizziness or severe headaches
- Cuts or burns
- Back pain
- High fever
- Sore throat
- Diabetes
- A baby's nonstop crying
- And much more

Plus when you call, you can access an audio library of more than 1,000 health topics – from allergies to surgeries – with more than 500 topics available in Spanish.

So, put the 24/7 Nurseline phone number in your contacts today, because health happens 24/7.

Call the 24/7 Nurseline number on the back of your member ID card.
Hours of Operation: Anytime

For medical emergencies, call 911. This program is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

9100078.0420

Compare plans

Get emergency medical transportation coverage to protect what matters most.

With a MASA plan, you'll have an additional layer of financial protection from the out-of-pocket costs of medical transportation. Explore the options below to compare the benefits offered in each plan.

Gain peace of mind and shield your finances knowing there's a MASA plan best suited for your needs.

	Emergent Plus plan	Emergent Premier plan	Platinum plan
Emergency Ground Ambulance Coverage	● [2]	● [2]	● [2]
Emergency Air Ambulance Coverage	● [2]	● [2]	● [2]
Hospital to Hospital Ambulance Coverage	● [2]	● [2]	● [2]
Repatriation to Hospital Near Home Coverage	● [2]	● [3]	● [4]
Post Admission Continued Care Transportation Coverage		● [1]	
Sick While Away From Home Expense Protection		● [4]	
Minor Return Transportation Coverage		● [3]	● [3]
Pet Return Transportation Coverage		● [3]	● [3]
Patient Return Transportation Coverage			● [4]
Companion Transportation Coverage			● [3]
Hospital Visitor Transportation Coverage			● [3]
Mortal Remains Transportation Coverage			● [4]
Vehicle & RV Return Coverage			● [3]
Organ Retrieval & Organ Recipient Transportation Coverage			● [1]

Coverage territories

1: United States only.

2: United States, Canada.

3: United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas and Bermuda.

4: Worldwide coverage to include any region with the exclusion of Antarctica and not prohibited by U.S. law or under certain U.S. travel advisories as long as the member has provided ten (10) day notice.

Benefit descriptions

Emergency Ground Ambulance Coverage

MASA covers out-of-pocket expenses for emergency ground transportation to a medical facility for you or your dependent family member.

For policies that provide an indemnity benefit, MASA pays you an indemnity amount for your or your dependent family member's emergency ground transportation to a medical facility.

Emergency Air Ambulance Coverage

MASA covers out-of-pocket expenses for emergency air transportation to a medical facility for you or your dependent family member.

For policies that provide an indemnity benefit, MASA pays you an indemnity amount for your or your dependent family member's emergency air transportation to a medical facility.

Repatriation to Hospital Near Home Coverage

Should you need continued care, and your care provider has approved moving you to a hospital nearer to your home, MASA coordinates and covers expenses for ambulance transportation to the approved medical facility.

Hospital to Hospital Ambulance Coverage

When specialized care is required but not available at the initial emergency facility, MASA provides coverage for transferring you to the nearest appropriate medical facility.

Post Admission Continued Care Transportation Coverage

Should you need care in a rehabilitation facility, skilled nursing facility, long-term care facility, hospice, or at home after an emergency, your out-of-pocket expenses for transport are eased with MASA.

Sick While Away From Home Expense Protection

Should you be required to quarantine while traveling, MASA will cover some of your extended hotel expenses.

Minor Return Transportation Coverage

In the event your minor child traveling with you is left unattended due to your emergency transport, MASA coordinates services and covers expenses to return your child safely home.

Hospital Visitor Transportation Coverage

Should you be hospitalized more than 100 miles from home, MASA coordinates and covers the cost of round-trip air transportation for a companion to join you.

MASA Deductions	Monthly Premiums
Emergent Plus Plan	$13.00
Emergent Premier Plan	$17.50
Platinum Plan	$37.00

Patient Return Transportation Coverage

Once you're discharged from medical care and able to travel without medical transport, MASA coordinates and covers costs associated with your commercial airline transport home.

Companion Transportation Coverage

MASA coordinates services and covers costs for a companion to accompany you during your emergency air ambulance transport.

Companion Return Transportation Coverage

Once you're discharged from medical care and able to travel without medical transport, MASA coordinates and covers the costs associated with your companion accompanying you on commercial airline transport home.

Pet Return Transportation Coverage

If you are traveling with your pets and an emergency occurs requiring your medical transport, MASA coordinates services and covers expenses for returning up to two pets to your home.

Mortal Remains Transportation Coverage

In the event that you pass away more than 100 miles from home, MASA coordinates services and provides coverage for air transport for your remains to be returned home.

Vehicle & RV Return Coverage

Should a travel emergency occur requiring you to leave your vehicle or RV by ambulance, MASA provides services and covers expenses associated with returning your vehicle or RV to your home.

Organ Retrieval Transportation Coverage

Should you need an organ transplant, MASA coordinates and provides coverage for getting you or the organ to the transplant location.

About MASA

In 1974 MASA pioneered the first prepaid plan program providing coverage for medical emergency air and ground transportation costs.

Now with over 400 team members, MASA is offered throughout the U.S. — and provides complete nationwide coverage for emergency transportation.

Protect your employees, their families, and their financial future with MASA.

HEALTH SAVINGS ACCOUNT

Consolidated Admin Services (CAS)

A Health Savings Account (HSA) works with a High Deductible Health Plan (HDHP), and lets you set aside a portion of your paycheck, before taxes, into an account to help you pay for qualified medical expenses that aren't covered by your plan. It can also help you plan for future medical expenses.

Note: *HSA funds can roll over from year to year!*

How does an HSA work?

In 2024, the IRS increased the HSA maximums. You can deposit up to $4,150 for yourself or up to $8,300 for your family, into your HSA. For those 55 and older, $1,000 catch-up (additional) contributions can be made to their HSA. This limit is set by the IRS. You can use money in your HSA to *pay for insurance deductibles and medical care/supplies like dentistry, ophthalmology, and prescription drugs*. When you enroll, an account will be created for you. There is a $2.50 administrative maintenance fee deducted each month from your paycheck. You'll be given access to a secure, easy-to-use web portal where you can track your account balance and submit requests for reimbursements.

In addition, you'll be issued an HSA Benefits Card you can use at point-of-sale to pay for qualified medical expenses. You can request reimbursement distributions online at *www.consolidatedadmin.com* or call **(877) 941-5956**. Payment will be made based on your available funds. Distributions can be made payable to you or a provider. Contributions above the yearly limit are called excess contributions and could be subject to a six percent excise tax.

IRS HSA Contribution Limits	2024
Individual	$4,150
Individual (age 55+)	$5,150
Family	$8,300
Family (age 55+)	$9,300

HSA Eligibility

You are eligible to open and contribute to an HSA if:

- You are enrolled in a High Deductible Health Plan (HDHP);
- You are not covered by your spouse or domestic partner's non-HDHP health plan;
- You are not eligible to be claimed as a dependent on someone else's tax return;
- You are not enrolled in Medicare or TRICARE; and
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care (service-related care will not be taken into consideration).

Triple Tax Savings!

You can take advantage of 'triple tax savings' when you open an HSA with Consolidated Admin Services (CAS). That's because...

- Your contributions are pre-tax (or tax deductible);
- Your account balance grows tax-free; and
- Withdrawals for qualified medical expenses are also tax-free.

FLEXIBLE SPENDING ACCOUNT

CAS

The Flexible Spending Accounts (FSA) administered by Consolidated Admin Services (CAS) allow you to set aside pre-tax dollars from your paycheck to pay for many health care and dependent care expenses. By paying for these expenses with pre-tax dollars, you reduce the amount of your taxable income and increase your take-home pay. You may choose to participate in one or both FSAs - whether you elect any other benefits.

How much can I contribute?

To participate, decide how much you would like to contribute to one or both accounts for the year. *The money you allocate to each account is automatically deducted from your paycheck each pay period before taxes are calculated.*

- Health Care Flexible Spending Account you could contribute up to the maximum of $3,200 for the 2024 year.
- Dependent Care Flexible Spending Account you could contribute up to the maximum of $5,000 for the 2024 year. The exceptions are:
  - If you and your spouse file separate tax returns, you may contribute $2,500 per year.
  - If your spouse is employed, your maximum contribution is the lesser of your spouse's taxable income (but no more than $5,000)
  - If your spouse is a full-time student or they are physically or mentally disabled, your maximum contribution is $2,500 a year if you claim expenses for one dependent and $5,000 a year if you claim expenses for two or more dependents.

IRS FSA Contribution Limits	2023	2024
Health Care Flexible Spending Account (Individual)	$3,050	$3,200
Dependent Care Flexible Spending Account	$5,000	$5,000

Note: *Health Care FSA funds can carryover a maximum of $640 for the year of 2024. There is a $3.50 administrative maintenance fee per account deducted each month from your paycheck.*

General Rules and Restrictions

In exchange for the tax advantages FSAs offer, the IRS has imposed the following rules and restrictions for both Health Care FSA and Dependent Care FSA:

- You may only use the money in your FSAs to reimburse expenses that you have incurred during the plan year for which the FSA was established.
- IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the "use it or lose it" rule.
- You cannot transfer monies between Health Care and Dependent Care FSAs.
- You cannot begin, stop, or change the amount of your FSA contributions during the calendar year unless you experience a Qualifying Life Event (such as: marriage, divorce or the birth/adoption of a child). Create an iHelp ticket to make changes to your benefits due to a qualifying life event.
- You cannot claim expenses that are reimbursed through your FSA as a deduction on your income tax return.
- Reimbursement for Dependent Care FSA claims is only up to the total amount that is in your account at that time.
- The dependent care provider cannot be anyone considered your dependent for income tax purposes (such as one of your older children). In order to be reimbursed, you are required to provide the tax identification number or Social Security number of the party providing care.

DENTAL

BCBSTX

BlueCross BlueShield of Texas (BCBSTX) gives you the freedom to choose whether you would like to visit an in-network or an out-of-network dentist. There are considerable cost savings when using a dentist who is in network. The following is a brief summary of the major plan provisions.

Network: BlueCare Dental
See www.bcbstx.com or call **(800) 521-2227** for a list of network providers.

Highlights	Low PPO Plan		High PPO Plan	
	In-Network	*Out-of-Network (UCR 90th)*	*In-Network*	*Out-of-Network (UCR 90th)*
Calendar Year Deductible Individual Family Waived for	$50 $150 Preventive		$50 $150 Preventive	
Annual Maximum Benefit	$1,250		$1,500	
Orthodontia Lifetime Maximum	None		$1,000	
Diagnostic & Preventive	100%	100%	100%	100%
Basic	80%	80%	80%	80%
Major	N/A	N/A	50%	50%
Orthodontia	N/A	N/A	50%	50%
Diagnostic & Preventive	• Periodic oral evaluations • Comprehensive oral evaluations • Prophylaxis (cleanings) • Topical fluoride applications • Full-mouth and panoramic films • Bitewing films • Space maintainers • Problem focused oral evaluations • Periapical films		• Periodic oral evaluations • Comprehensive oral evaluations • Prophylaxis (cleanings) • Topical fluoride applications • Full-mouth and panoramic films • Bitewing films • Space maintainers • Problem focused oral evaluations • Periapical films • Sealants	
Basic	• Basic Restorative Dental Services • Non-Surgical Extractions • Adjunctive Services		• Basic Restorative Dental Services • Non-Surgical Extractions • Non-Surgical Periodontic Services • Adjunctive Services • Endodontic Services • Oral Surgery Services • Surgical Periodontal Services	
Major	N/A		• Prefabricated crowns • Major Restorative Services • Prosthodontic Services • Recementations • Post and core, pin retention and crown/bridge repairs • Adjustments	
Orthodontia *(dependent child to age 19 only)*	N/A		Diagnostics and Treatment	

Dental Deductions	Monthly Premiums	
	Low PPO Plan	*High PPO Plan*
Employee	$22.22	$39.52
Employee + Spouse	$43.58	$79.28
Employee + Child(ren)	$59.20	$69.60
Family	$87.42	$112.30

BlueCare Dental BlueMax Advantage℠

Blue Cross and Blue Shield of Texas (BCBSTX) presents a creative benefit solution that may be right for your group's changing needs. BlueCare Dental BlueMax Advantage is an optional dental benefit that allows you to increase the annual benefit maximums for your covered employees based on the length of time they are enrolled in your group's dental plan. BCBSTX offers the BlueCare Dental BlueMax Advantage dental benefit option to all dental plans for groups of 151+ employees.

Flexibility for You and Your Employees

If you decide this optional benefit is right for you, it may help you manage the cost of current and future dental benefit expenses while:

- Providing enhanced benefits to employees who continue enrollment with the dental plan year after year
- Giving employees flexibility in planning and budgeting for dental care

See the reverse side for a sample BlueCare Dental BlueMax Advantage benefit offering.

VISION

BCBSTX / EyeMed

BlueCross BlueShield of Texas (BCBSTX) / EyeMed is pleased to present to you vision benefits designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health.

Network: Insight
See member.eyemedvisioncare.com/bcbstx/en or call **(855) 556-8796** for a list of network providers.

Highlights	Vision Plan	
	In-Network	*Out-of-Network (Reimbursement)*
Exam with dilation as necessary	$10 copay	Up to $45
Retinal Imaging	$39 copay	N/A
Lenses Single Bifocal Trifocal Lenticular	$10 copay	Up to $30 Up to $50 Up to $65 Up to $100
Contact Lenses* Contact Lens Fit and Follow Up Medically Necessary Conventional Disposable	Standard: Up to $40; Premium: 10% off retail price $0 copay, Paid in full $0 copay/$130 Allowance/15% off balance $0 copay/$130 Allowance/Plus balance over $130	N/A Up to $210 Up to $105 Up to $105
Frames	$0 Copay/$130 Allowance/20% off balance over $130	Up to $105
Service Frequencies Exams Lenses or Contact Lenses Frames	Every 12 months Every 12 months Every 12 months	
Additional Coverages	Lasik or PRK from U.S. Laser Network: 15% off retail price or 5% off promotional price	N/A
	Additional pairs benefit: Members also receive a 40% discount off complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A

**Contact lenses are in lieu of eyeglasses and frames.*

Vision Deductions	Monthly Premiums
Employee	$6.48
Employee + Spouse	$12.94
Employee + Child(ren)	$13.66
Family	$21.44

BlueCross BlueShield of Texas

Vision Care

Got questions about your vision plan?
We Can Help!

Your Questions Answered

Q: My eyes are fine. Do I really need to have them checked regularly?

A: Yes, regular eye exams are the way to go. It's not just about correcting your vision—it's about overall health. Eye exams can spot health conditions—like glaucoma, diabetes, cataracts and hypertension—early. The sooner these issues are spotted, the sooner you can get treatment.

Q: Will I save more money with this vision care benefit, or with an eyewear coupon or other promotional offer?

A: Great question! There are lots of special offers and coupons out there. When you compare them to your plan coverage, you'll likely find that your vision plan saves you more money in almost every case. A nice bonus is that you can use your vision benefit whenever you need to. Say goodbye to coupon expiration dates and limited time offers.

Keep in mind that your benefit can't be combined with any other discounts or promotional offers. Naturally, you're responsible for copays, any remaining out-of-pocket expenses and applicable sales tax.

Q: Can I get new contacts and glasses in the same year?

A: Every 12 months, you can get either contacts or spectacle lenses. Check your plan's benefits summary for additional frequencies, such as updating your look with new frames every 24 months.

Q: Do I need to have my ID card with me to use my benefits?

A: Nope. An in-network provider only needs your name and date of birth.

Q: How do I get another member ID card?

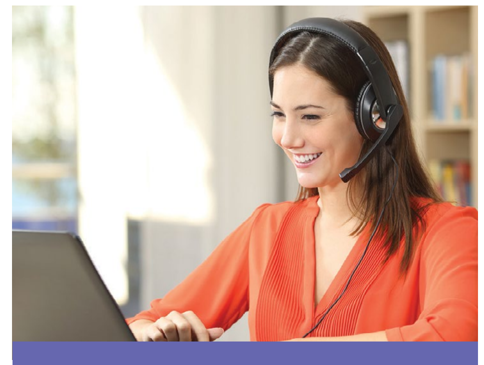
A: If your member ID card gets lost, no worries! You don't even need one to receive service. But if you want an additional card, you can access one and print it through our website eyemedvisioncare.com/bcbstxvis.

Q: What's included in a covered exam? Is dilation an extra cost?

A: No worries, we've got you covered. Eye exams at participating providers include dilation and other important eye health tests. There are no added out-of-pocket costs (other than a copay, if applicable).

Q: How does the standard lens benefit work?

A: It's simple. We give you a standard plastic lens—either single vision or lined multifocal—as part of the covered benefit. You're only responsible for a copay, if applicable, and taxes.



How do I get in touch with the Customer Care Center?

It's easy! You can talk to a representative—a real person—by calling 855-556-8796. Also, you'll find automated features online at eyemedvisioncare.com/bcbstxvis or through our automated voice response system.

Hours of live operation:

Monday – Saturday
6:30 a.m. to 10:00 p.m. CST

Sunday
10:00 a.m. to 7:00 p.m. CST

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148.

Help Your Employees Manage Life Challenges

We have partnered with ComPsych® to provide an Employee Assistance Program (EAP) integrated with your Blue Cross and Blue Shield of Texas (BCBSTX) plan. Through this program, your employees will get a core set of services to help them manage life challenges, including:

Local, Professional, In-Person or Virtual Counseling Services

The EAP provides local, in-person counseling through a worldwide network of qualified licensed professionals. This ensures that employees receive the right help at the right time, which results in better focus at work, greater productivity, less absenteeism and reduced medical costs. Members can chose a provider that participates in ComPsych's network.If EAP visits are exhausted, your employees can continue to use their medical benefits. They will be directed to a BCBSTX provider to get the most from their benefits.

Management Consulting

When managers and supervisors need another perspective on how to best support your employees, the EAP can help.

ComPsych GuidanceResources® employee relations generalists are available to provide information, and resources regarding behavioral health and substance abuse issues, potential workplace violence, organizational changes, or any other employee-related situation.

ComPsych Corp. is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide employee assistance services for members with coverage through BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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Critical Incident Stress Management

A team's sudden loss of a close co-worker, an episode of workplace violence, or even a workplace accident can be a cause for the disruption of your staff's wellbeing and sense of safety in the workplace. Critical Incident Stress Management can reduce the potential for employees experiencing long-term emotional and/or psychological consequences.

A toll-free number is available 24 hours a day, 7 days a week. A coordinator will assist and determine the best course of action to take to address the crisis.

Substance Use Assessment

If an employee fears that they, a family member or a colleague is abusing drugs or alcohol or is suffering from addiction, help is available through our program. The help is completely confidential and provided at no cost to members.

A counselor will work with individuals to determine the best resources for their situation. That may be short-term counseling, help setting goals, referrals to a specialist, and information to support healthy, positive changes.

Integration and Reporting

Through integration and reporting, we offer an EAP solution to help improve efficiency and savings:

- We offer a coordinated, comprehensive, adaptable EAP solution
- One-stop shop for behavioral health, well-being, and financial/legal/personal care resources and referrals
- Multiple access points to care (web, telephonic, video chat/messaging) accommodates how, when and where members prefer to engage
- BCBSTX holds the contract, handles billing*, and integrates metrics for spend, utilization and outcomes
    - Integration leverages unique clinical points such as case management referrals, emergency services, crisis communications and clinical data exchange.
    - Holistic reporting shows if your population is getting better
    - Supported by BCBSTX communications

Through ComPsych and BCBSTX's integrated EAP, your employees will get the support and resources they need to balance work/family/life. For more information, please contact your BCBSTX Account Representative.

*BCBSTX will handle the majority of billing; ComPsych may bill directly to employers for select services.

Your Guide to GuidanceResources® Online

GuidanceResources.com

What about financial concerns?

Financial issues can arise at any time, from dealing with debt to saving for college. GuidanceResources® Online is available to provide you with the tools and information you need to help solve your personal money management concerns.

How can I manage all of my life's little details and the issues my family may face?

Whether you are a new parent, giving care to an elder, sending a child off to college, buying a car or doing home repairs, you're bound to come across concerns that need to be addressed. Let GuidanceResources® Online help you explore your options.

Where can I get answers to my legal questions?

GuidanceResources® Online provides access to practical, understandable information and tools to help address your concerns about divorce, bankruptcy, buying real estate and other issues.

Guide to using GuidanceResources.com

1. On the **GuidanceResources.com** home page, click on the tab at the top labeled **"Register."**
2. Enter your **company ID: DISRES**. Create a **username and password**. The username has to be at least six characters long and should have no spaces (for example: joesmith). Make sure that you **complete all required fields, noted with red asterisks**.
3. Read the Terms of Use and click inside the checkbox to indicate your agreement to those terms.
4. When you've finished, **click on the "Submit" button** at the bottom of the page.

For illustrative purposes only. May not be available in all jurisdictions. Coverage may be subject to limitations, exclusions and other coverage conditions contained in the issued policy. Please consult the policy for the actual terms of coverage.

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GuidanceResources® Online offers web-based services designed to help address the personal concerns and life issues you may be facing. Whether it's depression, alcohol and drug abuse, or grief and loss, these services are available to you and members of your family at no cost—24 hours a day, 7 days a week.

ONLINE ACCESS:

GuidanceResources.com

- Click "Register" to create a new account.
- Enter Your Company ID: DISRES
- FOR FUTURE LOGINS, just go to the member login section and enter your username and password. This will take you directly to **GuidanceResources.com**.

If you have any problems logging in, you can contact: **memberservices@ guidanceresources.com or 877-595-5289**.

Disability Resource Services™

In the U.S. and Canada call

866-899-1363

TDD: 800-697-0353

guidanceresources.com

Enter Your Company ID: DISRES

BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association.

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DISABILITY

Dearborn Life

SHORT-TERM DISABILITY (STD) - Employee Paid

Dearborn Life's Short-Term Disability insurance can replace a portion of your weekly income if you have a covered disability that keeps you from working. As long as you remain disabled, you can receive payments for up to ***25 weeks***. You're generally considered disabled if you're unable to do important parts of your job and your income suffers as a result. This plan covers off-the-job injuries and illnesses only. Employees are required to use PTO days prior to filing a claim.

Highlights	Short-Term Disability
Weekly Benefit	Up to 60% of weekly salary in $50 increments (up to $1,000 per week)
Elimination Period	7 days following injury or illness
Benefit Duration	25 weeks
Pre-Existing Limitations	3 month look back / 12 month waiting period

Please speak to a licensed Benefit Counselor for personalized rates.

LONG-TERM DISABILITY (LTD) - Employer Paid

Dearborn Life's Long-Term Disability Insurance provides income replacement benefits for you and your family in the unfortunate event you are unable to work due to injury or illness. This plan covers both on- or off-the-job injuries and illnesses.

Highlights	Long-Term Disability
Monthly Benefit	50% of monthly salary (not to exceed $7,500)
Elimination Period	180 days following injury or illness
Benefit Duration	To Social Security Normal Retirement Age (SSNRA)
Pre-Existing Limitations	3 month look back / 12 month waiting period

Why is STD and LTD coverage so valuable?

- **It's flexible.** You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.
- **It's affordable.** Your cost is based on your age when you buy the insurance and will not increase when you move into the next age band.
- **It's convenient.** Your premiums are automatically deducted from your paycheck.

BlueCross BlueShield of Texas

Disability Insurance

Disability Resource Services™

Help When It's Needed Most

When personal problems arise, many choose to cope alone, resulting in negative consequences at home and the workplace. This is why we have teamed with ComPsych® Corporation to offer employees covered by a long-term disability program and their immediate family an easy and convenient way to find the help they need. Whether it's an emotional, legal or financial issue, Disability Resource Services provides the resources for support and solutions.

For Long-Term Disability Insured Employees

Face-to-Face Sessions

Disability Resource Services provides three face-to-face sessions per issue in a geographically accessible location to address behavioral issues.

Unlimited Telephonic Support

Disability Resource Services also provides unlimited telephonic support (24 hours a day, 7 days a week) to help address behavioral issues. Master's degree level clinicians use a conversational approach to identify issues, assess needs and refer participants to specialists to help resolve their issues.

Web-Based Services

GuidanceResources® Online (guidanceresources.com) is a secure, password-protected interactive website that contains self-assessments, search tools, extensive content on personal health and powerful tools to help with personal, relational, legal, health and financial concerns. This service is free of charge to employees who are insured with us for long-term disability insurance and their immediate family.

Assistance through GuidanceResources® Online is available 24 hours a day, 7 days a week and covers many topics and personal concerns, such as:

- Alcohol and drug abuse
- Depression
- Divorce and family law
- Estate planning
- Getting out of debt
- Grief and loss
- Job pressures
- Managing debt obligations
- Marital and family conflicts
- Retirement planning
- Saving for college
- Stress and anxiety
- Tax questions
- Real estate buying and selling

Helping Improve Productivity for Long-Term Disability Insured Employees and Their Immediate Family

- Face-to-face sessions
- Unlimited telephonic support
- Web-based services available through guidanceresources.com

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LIFE AND AD&D

Dearborn Life

GROUP BASIC LIFE INSURANCE & AD&D - Employer Paid

Uplift Education provides Basic Life insurance and Accidental Death and Dismemberment (AD&D) insurance through Dearborn Life. Uplift Education provides Basic Life insurance **equal to the employee's salary (rounded to the next-highest $1,000) up to a maximum of $100,000** at ***no cost to you during your employment***. Please ***call*** the Benefits Service Center ***to designate or update beneficiary information***.

The AD&D insurance provides a monetary benefit to an employee or beneficiary when the employee experiences certain bodily injuries or death resulting from a covered accident while insured. The company provides a guaranteed issue amount equal to the basic life insurance amount.

Note: *Life and AD&D benefit reduces to 65% at age 65 and to 50% at age 70.*

VOLUNTARY LIFE INSURANCE - Employee Paid

In addition to the company paid life insurance, you have the opportunity to elect additional life insurance through Dearborn Life. AD&D amount will reflect the Voluntary Life insurance amount.

Highlights	Voluntary Life and AD&D
Employee Benefit	
Benefit Amount	Increments of $10,000 up to the lesser of 5 times annual salary or $500,000
Maximum Benefit	$500,000
Guarantee Issue	$300,000
Spouse Benefit	
Benefit Amount	Increments of $5,000 to a max of $100,000 not to exceed 50% of employee benefit
Maximum Benefit	$100,000
Guarantee Issue	$30,000
Child Benefit	
Benefit Amount	$10,000
Maximum Benefit	$10,000
Guarantee Issue	$10,000

Note: *Voluntary Life and AD&D benefit reduces to 65% at age 65 and to 50% at age 70. Employees may elect additional coverage with the submission and approval of an Evidence of Insurability form.*

Please speak to a licensed Benefit Counselor for personalized rates.

ACCIDENT

Guardian

You do everything you can to keep your family safe, but accidents do happen. It's comforting to know you have help to manage the medical costs associated with accidental injuries, both on and off the job. Guardian's Accident insurance pays a scheduled cash benefit upon diagnosis of covered accident injuries. The Accident policy will pay a ***$50 wellness benefit*** once per calendar year, per person.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like copays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You may keep your coverage if you change jobs or retire. You'll be billed directly.

Highlights	Plan
Wellness Benefits *(per calendar year)*	$50
Employee Accidental Death	Employee: $50,000 Spouse: $20,000, Child: $10,000
Common Carrier Accidental Death	200% of death benefit
Dismemberment	Up to 100% of AD&D benefit
Urgent Care *(per visit)*	$100
Follow-up Visits *(up to 6 visits)*	$100
Urgent Care *(per visit)*	$100
Major Diagnostic Exams *(per service)*	$200
Ambulance - Ground/Air *(per service)*	$200 / $1,000
Major Surgery	Up to $2,000
Fractures	Up to $10,000
Dislocations	Up to $8,000
Concussion *(per concussion)*	$200
Coma *(per coma)*	$12,500
Lacerations	Up to $800
Eye Injury *(per injury)*	$400
Hospital Admission *(per admission)*	$2,000
Intensive Care Admission *(per admission)*	$4,000
Daily Hospital Confinement *(per day, up to 1 year)*	$400
Intensive Care Daily Confinement *(per day, up to 15 days)*	$800
Physical Therapy *(up to 10 per accident)*	$50
Emergency Room Treatment *(per visit)*	$200
Transportation *(3 times per accident)*	Up to $600
Lodging *(per day, up to 30 days)*	$200

Accident Deductions	Monthly Premiums
Employee	$17.26
Employee + Spouse	$25.44
Employee + Child(ren)	$32.80
Family	$40.98

CRITICAL ILLNESS

Guardian

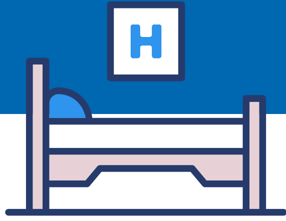
Guardian's Critical Illness insurance pays a lump-sum cash benefit upon diagnosis of a covered Critical Illness, to help ease your financial and emotional worries. You can use the benefit any way you wish, such as treatment, bill, or child care. The Critical Illness policy will pay a ***$50 wellness benefit*** once per calendar year, per person.

Why should I buy coverage now?

- It's more affordable when you buy it through your employer.
- The cost is conveniently deducted from your paycheck.
- You may keep your coverage if you change jobs or retire. You'll be billed directly.

Highlights	Plan	
Benefit Amount Employee Spouse Child	$5,000 to $50,000 in increments of $5,000 $2,500 to $25,000 in increments of $2,500 up to 50% of the employee benefit 25% of employee benefit	
Guaranteed Issue Employee Spouse Child	$50,000 $25,000 All child amounts are guaranteed	
	1st Occurrence	*2nd Occurrence*
Invasive Cancer	100%	100%
Heart Attack	100%	100%
Organ/Heart Failure	100%	100%
Kidney Failure	100%	100%
Stroke	100%	100%
Loss of Hearing, Sight or Speech	100%	0%
Coma	100%	0%
Permanent Paralysis	100% for 2 limbs, 50% for 1 limb	0%
Benign Brain Tumor	75%	0%
Alzheimer's Disease	50%	0%
Carcinoma in Situ	30%	0%
Coronary Arteriosclerosis	30%	0%
Infectious Contagious Disease	30%	0%
Skin Cancer	$250	Not covered

Please speak to a licensed Benefit Counselor for personalized rates.



HOSPITAL INDEMNITY

Guardian

Guardian's Hospital Indemnity plan can complement your health insurance to help you pay for the costs associated with a hospital stay. It can also provide funds that can be used to help pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, copays, and deductibles.

This plan also allows you to continue coverage in the event that your employment ends or when the policy is terminated and not being replaced.

Note: *The benefits in this plan are compatible with a Health Savings Account (HSA).*

Highlights	Plan
Hospital Admission *(1 day per year)*	$1,000
Daily In-Hospital Benefit *(per day, up to 15 days)*	$200
ICU Admission *(1 day per year)*	$1,000
ICU Daily Confinement *(per day, up to 15 days)*	$200
Health Screening Benefit *(once per year)*	$50

Hospital Indemnity Deductions	Monthly Premiums
Employee	$21.94
Employee + Spouse	$39.36
Employee + Child(ren)	$34.86
Family	$52.28

CANCER

Guardian

While most people can appreciate the importance of having health and disability insurance, the costs of cancer can go well beyond what those cover. Cancer Insurance is an affordable way to provide additional funds to help cover out-of-pocket expenses.

The average out-of-pocket cost for patients with cancer is estimated to be $8,436 a year, including copays, deductibles, treatments, home healthcare, and more. That's on top of everyday bills like groceries, utilities, and car payments. Cancer Insurance is an affordable way for you to address a barrage of costs while strengthening your employee benefit package.

Highlights	Low Plan	Medium Plan	High Plan
Hospital and Related Benefits (daily)			
Continuous Hospital Confinement *(first 31 days)*	$300	$300	$400
Government or Charity Hospital	N/A	$300	$400
Extended Care Facility *(up to 90 days per year)*	$100	$100	$150
At-Home Health Care *(up to 30 visits per year)*	N/A	$50 / visit	$100 / visit
Hospice Care Center *(up to 100 days per lifetime)*	$50	$50	$100
Cancer Initial Diagnosis	$5,000	$5,000	$5,000
Radiation, Chemotherapy, and Healing			
Radiation / Chemotherapy for Cancer *(every 12 months)*	Up to $10,000	Up to $10,000	Up to $15,000
Blood, Plasma, and Platelets *(every 12 months)*	Up to $5,000 per year	Up to $5,000 per year	Up to $10,000 per year
Medical Imaging *(yearly)*	N/A	$100 (2 / year)	$200 (2 / year)
Immunotherapy *(per month)*	$500 ($2,500 max)	$500 ($2,500 max)	$500 ($2,500 max)
Surgery and Related Benefits			
Surgery	Up to $2,750	Up to $4,125	Up to $5,500
Anesthesia *(% of surgery)*	25%	25%	25%
Second Opinion *(per procedure)*	$200	$200	$300
RBone Marrow or Stem Cell Transplant			
Bone Marrow	N/A	$7,500	$10,000
Stem Cell *(50% for 2nd transplant)*	N/A	$1,500	$2,500
Miscellaneous Benefits			
New or Experimental Treatment *(every 12 months)*	N/A	Up to $1,000 / month	Up to $2,400 / month
Prosthesis *(Non-Surgically-Implanted)*	$200 / device	$200 / device	$300 / device
Prosthesis *(Surgically-Implanted)*	$2,000 / device	$2,000 / device	$3,000 / device
Anti-Nausea Benefit *(monthly)*	N/A	$150	$250
Waiver of Premium *(for primary insured only)*	Yes	Yes	Yes

Cancer Deductions	Monthly Premiums		
	Low Plan	*Medium Plan*	*High Plan*
Employee	$10.88	$21.70	$28.08
Employee + Spouse	$19.98	$40.62	$52.04
Employee + Child(ren)	$12.72	$27.84	$35.14
Family	$21.82	$46.76	$59.10

UNIVERSAL LIFE

Transamerica

There is no way to know what will happen tomorrow. But there is a way to help ensure you are protected against the unexpected. Transamerica Life Insurance Company's Universal Life insurance can help meet your family's future financial needs in the event of your premature passing. Prudent financial planning can help protect your family's future, offering them greater peace of mind.

Highlights	Plan
Employee Benefit Amount Guarantee Issue - New Hires Only	 Up to $100,000 Up to $100,000 ($10,000 increments) not to exceed 5x your annual salary
Spouse Benefit Amount Guarantee Issue - New Hires Only	 $25,000 $25,000
Child Term Rider Benefit Amount Guarantee Issue	 $20,000 $20,000
Additional Benefit Riders	• Accelerated Death Benefit for Qualified Terminal Condition • Accelerated Death Benefit for Living Benefit • Benefits Restoration
Additional Advantages	• Keep your coverage at the same price and benefits if you change jobs or retire. • Apply for coverage for family members: spouse, children and grandchildren. • Convenient payroll deduction; pay via direct bill, bank draft or credit card if you leave your employer.

Please speak to a licensed Benefit Counselor for personalized rates.

Note: *For the **2024-2025 Plan Year**, TransAmerica has approved a special enrollment window from July 8 to July 29. During this period, returning employees who had previously waived coverage can now apply for insurance for themselves and their spouses, up to the Guarantee Issue limits specified above, without being required to answer health-related questions.*

This is a brief summary of TransElite® Universal Life Insurance underwritten by Transamerica Life Insurance Company (TLIC), Cedar Rapids, Iowa. TLIC is not an authorized insurer in New York. Policy Form Series CPGUL300 and CCGUL300. Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

Supplement Health

Filing supplemental health claims just got easier

We understand that submitting claims should be fast, simple and uncomplicated. Our Accident, Cancer, Critical Illness and Hospital Indemnity claims can be submitted several ways to help ensure accurate payments. And, now our wellness and supplemental health claims can be submitted in a way that's best for employees.

9 out of 10 of our customers are extremely satisfied with our helpfulness, easy claims process and quick payments.[1]

Filing a claim online

Online claim submission is among one of the most efficient way to submit a claim and will help reduce administrative time for both employees and our claims processing area. When you file your claim online you receive:

- Greater security and accuracy of data
- Faster processing and payments

Filing a claim by phone

For questions about your claim or to submit your claim via telephone, call 1-800-541-7846. Please take a moment to gather all the required information before making your call.

Filing a claim by mail

Download the form for your claim at guardianlife.com. You can complete the form on your computer, or you can print it out blank and complete it by hand. Once your claim form is filled out, mail it with the claim details and receipts to the address on the bottom of the claim form.

Filing a claim by fax

You can also fax your claim to 1-920-749-6299.

Guardian works smarter

We work smarter to keep claims submission easy for you - by offering a simple claims process, you can focus on your recovery. And, we're always looking for ways to make the claims submission even smoother for you .

For more information or questions contact your Guardian Group Representative or Guardian Broker.

The Guardian Life Insurance Company of America
New York, NY

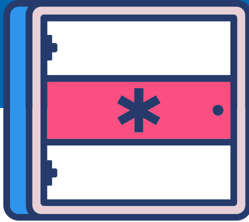
guardianlife.com

2020-113642 (12/21)

[1]Guardian Claims VOC Scorecard: Supplemental Health, 3Q 2019. Insurance products are underwritten and issued by The Guardian Life Insurance Company of America, NY, NY. Products not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are final arbiter of coverage. GUARDIAN® is a registered service mark of The Guardian Life Insurance Company of America. ©Copyright 2020 The Guardian Insurance Company of America.

403(B) RETIREMENT

TCG Group Holdings



A 403(b) plan allows an employee to defer money into a retirement account on a pre-tax or ROTH basis. The earnings in your retirement savings plan may be tax-deferred or tax-free depending on your contribution type. Eligible employees can enroll in a 403(b) retirement plan immediately upon hire and may change their deferral amount at any time.

For 2024, the maximum employee deferral to a 403(b) account is **$23,000 per calendar year**. Additionally, participants age 50 and older are permitted to contribute up to an additional **$10,000 in "catch-up"** contributions per calendar year. Uplift Education neither contributes to nor matches contributions for 403(b). A monthly administrative maintenance fee of $1.50 will be deducted in addition to your deferral election.

Interested in getting started? A list of Authorized Investment Providers with phone and website information is available on TCG Group Holdings' website. Detailed online enrollment instructions can be found at: *http://upliftedducationbenefits.org/403b/enrollment-instructions*

Plan Features

- Employees have a variety of investment options though TCG.
- You may stop or change your contribution at any time by logging into your online account at *www.region10rams.org* or by calling TCG at **(800) 943-9179**.

TCG Group Holdings

- **Customer Service:** (800) 943-9179
- **Fax:** (888) 989-9247
- *www.region10rams.org*
- **Email:** *403b@tcgservices.com*

Retirement Planning for Educators

Click link to view video: *player.vimeo.com/video/766265550*

Take Charge Towards a Secure Retirement

Personalized Guidance for District Staff Through TeleWealth™ Virtual Meetings

Whether retirement is near or far, planning for your financial future is essential. As a school district employee, you work tirelessly to support all students and the community. But now it's time to **prioritize your own financial wellbeing** and take control of your financial future.

TeleWealth™ Virtual Meetings

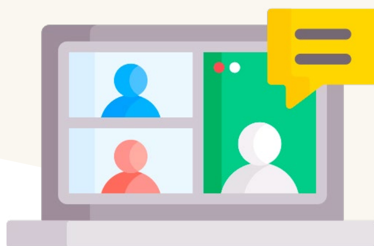
Convenient, Confidential, Free

Our team is here to help you evaluate your current situation, explore your plan options, and guide you towards your retirement dreams.

Join your meeting with ease from home or school via phone or computer. Meetings are 100% confidential and **free of charge for you and your spouse**.

Get answers to questions like:

- How does my pension work?
- How much will I need at retirement?
- Does Social Security impact the pension I'm supposed to receive?
- What are 457(b) and 403(b) plans?
- How do I consolidate plans from previous employers?
- How do I choose what to invest in?



Schedule a TeleWealth™ Meeting at

www.tcgservices.com/telewealth

For extended hours or weekends, please email hello@tcgservices.com

Scan code for quick meeting booking access

Advisory services and TeleWealth virtual meetings offered through TCG Advisors LLC, a HUB International company, an SEC Registered Investment Advisor. Insurance offered through HUB International. TCG.59.2023

Pet insurance

from Nationwide®

Fetch the best health coverage for your pet through your voluntary benefits package. With two budget-friendly plans, there's never been a better time to sign up for My Pet Protection®, available only through your workplace benefits program.

Nationwide offers two plans for you to choose from: My Pet Protection® and My Pet Protection® with Wellness500.[1]

Both plans are guaranteed issuance,[2] have a $250 annual deductible and include medical coverage with the choice of 50% or 70% reimbursement levels.[3]

	My Pet Protection®	My Pet Protection® with Wellness500
Accidents	✓	✓
Injuries	✓	✓
Illnesses	✓	✓
Hereditary and congenital conditions	✓	✓
Diagnostics and imaging	✓	✓
Procedures and surgeries	✓	✓
Wellness exams		✓
Vaccinations		✓
Flea prevention		✓
Spay or neuter		✓
And more	✓	✓

Did you know? Nationwide is the industry-first provider of coverage for birds and exotic pets.

How to use your pet insurance plan

1 Visit any vet, anywhere.

2 Submit claim.

3 Get reimbursed for eligible expenses.

https://benefits.petinsurance.com/uplifteducation | 877-738-7874

[1] Existing members can enroll in My Pet Protection® with Wellness500 during their respective renewal period only. Products and discounts not available to all persons in all states. [2] Guaranteed issuance means any new pets enrolling into a My Pet Protection Plan are eligible for enrollment regardless of health status. Guaranteed issuance does not mean guaranteed coverage since certain exclusions could apply. [3] These are examples of general coverage; please review plan document for specific coverages. Some exclusions may apply. Certain coverages may be excluded due to pre-existing conditions. See policy documents for a complete list of exclusions and annual limits.

Products underwritten by Veterinary Pet Insurance Company (CA), Columbus, OH; National Casualty Company (all other states), Columbus, OH. Agency of Record: DVM Insurance Agency. All are subsidiaries of Nationwide Mutual Insurance Company. Subject to underwriting guidelines, review and approval. Products and discounts not available to all persons in all states. Insurance terms, definitions and explanations are intended for informational purposes only and do not in any way replace or modify the definitions and information contained in individual insurance contracts, policies or declaration pages, which are controlling. Nationwide, the Nationwide N and Eagle, Nationwide is on your side, VetHelpline® and Nationwide PetRxExpress℠ are service marks of Nationwide Mutual Insurance Company. Third party marks are the property of their respective owners. ©2024 Nationwide. 23GRP9695A

Nationwide®

HEALTH INSURANCE TERMS

In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, health plans, and health care providers.

- **Benefits -** The amount of money payable by an insurance company to a claimant under the insurance policy.
- **Claim -** A request by an individual (or his /her provider) for the insurance company to pay for services obtained.
- **Co-insurance -** The money that an individual is required to pay for services, after deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20% of the charges while the health plan pays 80%.
- **Co-payment -** An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered.
- **Deductible -** A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual or contract year basis.
- **Exclusions and Limitations -** Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).
- **Health Savings Account (HSA) -** An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **Flexible Spending Account (FSA) -** An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **High Deductible Health Plan (HDHP) -** A health plan that meets the requirements of being considered an HDHP. There are NO copayments on an HDHP. All medical and prescription drug expenses are applied towards the calendar year deductible first, then once a member has satisfied his/her deductible, the coinsurance will apply.
- **In-Network -** Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.
- **Medically Necessary -** A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.
- **Out-of-Network -** Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.
- **Maximum Out-of-Pocket Maximum -** The total amount paid each year by the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that calendar year.
- **Pre-Existing Condition -** Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.
- **Preferred Provider Organizations (PPO) -** A type of managed care plan in which doctors and hospitals agree to provide discounted rates to plan members. Patients are typically reimbursed 80-100% for treatment received withing the network, versus 50-70% outside the network.
- **Primary Care Physician (PCP) -** A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP services as a gatekeeper for an individual's care, referring him or her to specialists and admitting him or her to hospitals when needed.
- **Reasonable and Customary Charges -** The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.
- **Explanation of Benefits (EOB)-** A summary of claims processed which will be provided to you after a claim is processed for you or for a dependent. This statement outlines year-to-date deductible and out-of-pocket amounts met during the year. This statement will be mailed unless it is turned off on the website.

FREQUENTLY ASKED Q&A

GENERAL

If I am already enrolled and not making any changes, do I have to complete the Open Enrollment process?

Yes. It is important that you review any rate or plan changes to your current plan.

If I want to decline coverage, must I still complete the Open enrollment process?

Yes. It is important that your employer has a record of your decision. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special qualifying event such as a marriage, divorce, birth or adoption of a child, or loss of other coverage.

Can I enroll my spouse or dependent on one plan and myself on another?

No. All covered dependents, including spouse, must be on the same plan as the employee.

Can I drop or change plans during the plan year?

Changes can only be made if there has been a qualifying event or personal life change. Examples include marriage, divorce, birth of a child, or change in employment status.

What is the difference between a calendar year and a contract year?

A plan on a calendar year runs from January 1–December 31. Items like deductible, maximum out-of-pocket expense, etc. will reset every January 1. All Individual and Family plans are on a calendar year. A plan on a contract year (also called benefit year) runs for any 12-month period within the year. Items like deductible, maximum out-of-pocket expense, etc. will reset at the plan's renewal date. For example, ABC Company renews on July 1 every year. Your deductible would start July 1 and end on June 30. The deductible would reset every July 1 for ABC Company members.

What happens if I sign up for insurance but find later on in the year that I cannot afford the premiums?

If the reason for your change in affordability is due to a life-changing event such as the loss of a job, death of a spouse, or birth of a child, you would be eligible for special enrollment within 30 days of the event. If you do not enroll during this period, you will not be assured a health plan will cover you either through the Health Insurance Marketplace or in the private market. If you do not pay your premium, you could lose coverage and will not be able to enroll again until the next open enrollment period.

Benefit payments

For benefits received in the Network, you are responsible only for your co-payment, deductible and coinsurance amounts. Your provider will file the claim.

MEDICAL

Should I notify my pharmacy and physician of my benefits plan with BCBSTX?

Yes. On your next visit to the pharmacy or doctor, simply present your BCBSTX ID card. This will allow the provider to correctly bill BCBSTX for the services you have received. It's important to inform your physician of the requirement to utilize an BCBSTX facility as a medical plan participant.

LEGAL NOTICES

FEDERAL LEGISLATION IMPACTING HEALTH CARE PLANS

Legislative Reminders Affecting Your Medical Plan

While our plans were already in compliance with these provisions, we are required to notify you of certain provisions on an annual basis. We would like to inform you of legislation that mandates coverage for you and your dependents. These benefits are included as part of your medical benefits to protect you and your family. No action is needed on your part.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans to provide coverage for breast reconstruction, prostheses and complications following a mastectomy. The law mandates that a Participant or Dependent who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomies, including lymphedemas.

This coverage will be provided in a manner determined in consultation with the attending Physician and the patient, and will be subject to the same annual Deductible, Coinsurance and/or Copayment provisions otherwise applicable under the Plan. If you have any questions about coverages for mastectomies and post-operative reconstructive surgery, please call your plan administrator at (800) 521-2227.

Newborn and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., your Physician, nurse or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits for out of pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

LEGAL NOTICES CONTINUED

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

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

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

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

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

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

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

NEVADA – Medicaid

Website: http://dhcfp.nv.gov
Phone: 1-800-992-0900

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

U.S. Department of Health and Human Sevices
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.

LEGAL NOTICES CONTINUED

Special Enrollment Notice

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

Loss of Other Coverage

If you are declining coverage 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).

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

Marriage, Birth or Adoption

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

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

Medicaid or CHIP

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

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

LEGAL NOTICES CONTINUED

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

LEGAL NOTICES CONTINUED

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

iHelp Tickets

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.

LEGAL NOTICES CONTINUED

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
Uplift Education		75-2659683
5. Employer address		6. Employer phone number
3000 Pegasus Park Drive, Suite 1100		
7. City	8. State	9. ZIP code
Dallas	TX	75247
10. Who can we contact about employee health coverage at this job?		
Jessica O'Leary		
11. Phone number (if different from above)	12. Email address	
(469) 621-8500	joleary@upliftededucation.org	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    PART-TIME EMPLOYEES - Employees working at least 10 hours but less than 30 hours per week are only eligible for medical insurance and do not qualify for the Uplift Education monthly cafeteria credit.
    EMPLOYEE ELIGIBILITY - New Hires have 30 days from their hire date to enroll in or decline benefits. All benefits are effective the first of the month following your hire date.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Determined by the insurance carriers and Texas Department of Insurance.
  - ☐ We do not offer coverage.

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

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

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

NOTES

uplift education

2024-2025 EMPLOYEE BENEFITS GUIDE