2024/2025 EMPLOYEE BENEFITS GUIDE FOR NEW EMPLOYEES

GEO ACADEMIES
BELIEVE

Table of Contents

Your To Do List

The following checklist will walk you through all steps required to enroll in your benefits for the plan year 2024/2025.

PREPARE

Educate Yourself to Make the Best Decision

- □ Review your health care costs from last year and estimate your personal and family health care needs for this year.
- □ Learn your 2024/2025 benefit options:

  Read this Benefit Guide.
- □ Make the following decisions:
  1. Who will you cover this year?
  2. Who do you need to remove from coverage because they are no longer eligible due to age or change of status?
  3. What plans will you elect?
  4. Will you contribute to a Health Savings Account (HSA); if so how much?
  5. Will you make changes to your retirement contribution?
  6. Will you change your beneficiaries?

IMPORTANT! For questions or to enroll in any of the voluntary benefits such as Voluntary life, Accident, critical illness, hospital indemnity or whole life you will need to call (855) 202-7340 between 8am-5pm central time from July 23rd until Aug 16, 2024.

ENROLL

Enroll in Your Benefits

Current Employees:
Complete during Open Enrollment: 07/23/2024 through 08/16/2024.

New Hires: Complete any time during your first 30 days of employment.

- □ Make sure you have your (and your qualified dependents') birthdate(s), address(es) and social security number(s) on hand.
- □ Go to Employee Navigator: the company identifier is – **GEO FD.**
- □ Review your existing coverage and/or select new coverage.
- □ Complete all enrollment elections and/or additional setup steps:
  1. Provide dependent eligibility documentation to HR before the end of your enrollment period.
  2. Setup your HSA with UMB Financial Corp.
- □ The online enrollment system will deliver an email to your GEO Academies email address when you submit your enrollment elections. Verify that your mailing address, dependent information, and elections are all correct. Save a copy of the Benefits Confirmation Statement which is attached to the message. Please contact HR as soon as possible if you find errors or have questions.

LAUNCH

Remember these Last Steps AFTER Enrollment is Complete

- □ You can make changes to your elections only during your enrollment period. Make sure you have chosen appropriately as you will not be able to make changes until next year's Open Enrollment OR unless you experience a qualifying event (see the Making Changes section in this guide).
- □ You will not receive new insurance cards unless you are electing benefits for the first time or changing benefits.
- □ Once the plan year begins, review your paycheck. If you notice errors in your payroll deductions, notify HR **IMMEDIATELY**!
- □ **IMPORTANT!** Provide your new insurance card(s) to your health care providers after the start of the plan year.

How GEO Academies is Helping to Take Care of You

At GEO Academies, we care about you and your family's wellbeing. From physical health to financial standing, we've got you covered throughout each stage of life. That's why we've put together a holistic benefits package – take a glance at your options below.

Benefit	Carrier	How GEO Academies Helps You & Your Family
Medical/Prescription Coverage	Unified Group Services True Rx / Rx Help Center	You & GEO Academies share the cost
Dental Coverage	Unified Group Services	You & GEO Academies share the cost
Health Savings Account	UMB Financial Corp.	You deposit 100% of the funds
Vision Coverage	Kansas City Life	You pay 100% of the premium
Short Term Disability	Kansas City Life	You pay 100% of the premium
Long Term Disability	Kansas City Life	GEO Academies pays 100% of the premium for you
Basic Term Life	Reliance Standard	GEO Academies pays 100% of the premium for you
Voluntary Life, Accident, Critical Illness, Hospitalization	Reliance Standard	You pay 100% of the premium for you
Whole Life	Atlantic American	You pay 100% of the premium for you
Employee Assistance Program	KEPRO	GEO Academies pays 100% of the premium
Retirement Plan	Voya	You and GEO Academies contribute
Pet Insurance	Nationwide	You pay 100% of the premium

Who is Eligible

Before you decide what plans you want to elect it helps to know *who* qualifies to receive our benefits. First, let's look at some definitions of who is eligible for what.

Definitions		Benefits Available					
		Medical	Rx	Dental	Vision	Life	Disability
Employee (EE)	As an employee of GEO Academies, you can enroll in our employee benefits if: • You are a regular full-time employee and/or • You are regularly scheduled to work 30 hours a week or more.	☺	☺	☺	☺	☺	☺
Spouse (SP)	Spouses eligible to enroll include: • Legal Spouse (either opposite-sex or same-sex, legally married in one of the 50 states, the District of Columbia, a US territory, or a foreign country) *See Working Spouse Rule	☺	☺	☺	☺	✖	✖
Child(ren) (CH)	Dependent Children are eligible to enroll if they are under age 26** and are one of the following (for you and/or your Spouse): • Biological child • Adopted or placed for adoption • Stepchildren • Under legal guardianship Any age who is legally dependent on you due to a physical or mental disability	☺	☺	☺	☺	✖	✖

COVERAGE BEGINS

If you are newly hired or qualify for our benefits, you have 30 days from date of hire/eligibility to enroll, and your benefits will go into effect 30 days from your date of hire / or on date of eligibility.

COVERAGE ENDS

For most benefits, your coverage will end on the day in which:

- Your regular work schedule is reduced to under 30 hours per week.
- Your employment with GEO Academies ends.
- You stop paying your premiums.

For your dependent(s), coverage ends:

- When your coverage ends or
- The last day of the month in which a dependent turns age 26

WORKING SPOUSE RULE

Is your spouse currently employed? Does his or her employer offer health coverage? If yes, your spouse is not allowed to enroll in GEO's medical benefits.

This rule is meant to encourage all individuals to take the benefits offered by their own employer. However, if your spouse is unemployed, does not have other coverage or is covered by Medicare/Medicaid, this rule does not apply.

Making Changes

Your new hire enrollment period and open enrollment are vital times of year for you and your employer. Because of IRS regulations, it is typically the only time during the year in which you can make changes to your benefit choices. Missing this vital deadline can mean losing coverage and/or being unable to change benefit elections unless you experience a qualifying event.

Qualifying Life Events are defined by the IRS and require certain documentation. Examples of events include but are not limited to:

CHANGE IN **Marital Status**

CHANGE IN **Number of Dependents**

CHANGE IN **Employment Status**

CHANGE IN **Court Ordered Coverage**

Wondering what's required when you experience a qualifying life event?

You will need to let Human Resources know **in writing** within 30 days of the event to make any changes necessary. Also, you will need to provide the required documentation. This includes:

- Proof of dependent relationship (marriage certificate, birth certificate, etc.)
- Any enrollment forms that may be required
- Dated documentation providing proof of the effective date of new coverage (or end of coverage) and names of individuals gaining or losing coverage.

If you do not elect coverage during your new hire enrollment period:

- You will not have GEO Academies coverage for the remainder of the plan year unless you experience a qualifying life event.

What is GEO Academies legally required to do?

Legally, employers are not required to do anything for employees who have missed the enrollment deadline. In fact, the terms of GEO Academies's benefit plans may prohibit them from making exceptions for those employees who do not make benefit elections within the allotted time.

HAVE SPECIFIC QUESTIONS ABOUT OPEN ENROLLMENT?

Please reach out to Human Resources TODAY!
We would rather have the conversation with you before it's too late. Missing your enrollment period severely limits and might even restrict our ability to help.

BE PREPARED.
The open enrollment process relies on you, the employee, to take action.

Medical & Rx

GEO Academies provides three medical plan options which are administered by **Unified Group Services and TrueRx**. Your healthcare network for 2024/2025 is **Cigna**. For full details, please refer to your plan documents.

IN-NETWORK & OUT-OF-NETWORK TIERS

Here's the good news: You can go to any provider you want to! The bad news? If you go to one that is not in the plan's network, you will be paying more money for those services. To find out if your primary care physician or pharmacy is in-network go to www.unifiedgrp.com. The In-Network and Out-of-Network tiers for each plan are broken down as follows:

At-A-Glance

	Hybrid PPO Option 1		HSA Qualified Option 2		HSA Qualified Option 3	
Network	**In-Network**	**Out-of-Network[3]**	**In-Network**	**Out-of-Network[3]**	**In-Network**	**Out-of-Network[3]**
Annual Deductible						
Single	$4,000	$8,000	$3,000	$6,000	$1,650	$3,000
Family[1]	$8,000	$12,000	$6,000	$12,000	$3,300	$6,000
Out-of-Pocket Maximum[2]						
Single	$7,350	$14,700	$6,450	$12,900	$3,000	$6,000
Family[1]	$14,700	$29,400	$12,900	$25,400	$6,000	$12,000
Other Costs	You Pay:		You Pay:		You Pay:	
Coinsurance Rate	20%	40%	20%	50%	20%	40%
Office Visits						
Routine Preventive Care	$0, plan pays 100%	Not Covered	$0, plan pays 100%	Not Covered	$0, plan pays 100%	Not Covered
Primary Care Physician	$30 Copay	Deductible, 40%	Deductible, 20%	Deductible, 50%	Deductible, 20%	Deductible, 40%
Specialist	$60 Copay	Deductible, 40%	Deductible, 20%	Deductible, 50%	Deductible, 20%	Deductible, 40%
Emergency Care						
Urgent Care	$50 Copay	Deductible, 40%	Deductible, 20%	Deductible, 50%	Deductible, 20%	Deductible, 40%
Emergency Room	$250 Copay, Deductible, 20%		Deductible, 20%		Deductible, 20%	
Inpatient/Outpatient						
Outpatient Surgeries	Deductible, 20%	Deductible, 40%	Deductible, 20%	Deductible, 50%	Deductible, 20%	Deductible, 40%
Inpatient Services	Deductible, 20%	Deductible, 40%	Deductible, 20%	Deductible, 50%	Deductible, 20%	Deductible, 40%
Account Attached to Plan[4]	**Not Applicable**		**HSA**		**HSA**	
Max Contribution Allowed Per Year	Not Applicable		$3,850 Employee Only $7,750 Family		$3,850 Employee Only $7,750 Family	
Catch up Contributions	Not Applicable		55 or older can contribute an extra $1,000		55 or older can contribute an extra $1,000	
Do Funds Carry Over?	Not Applicable		Yes		Yes	
Per Payroll Premiums	**Hybrid PPO Option 1**		**HSA Qualified Option 2**		**HSA Qualified Option 3**	
EE Only	$55.00		$89.00		$149.00	
EE + Spouse	$365.00		$367.00		$545.00	
EE + Child(ren)	$335.00		$357.00		$503.00	
Family	$660.00		$617.00		$831.00	

1. Family here is defined as Employee+Spouse, Employee+Child(ren) or Family. These employees also have what is called a non-embedded deductible, meaning the plan begins paying benefits that require cost sharing when the entire family deductible is met. The deductible can be met by one or a combination of several family members. The individual deductible applies to employee only coverage.
2. Out-of-pocket maximum includes the deductible and includes copays.
3. Amounts ABOVE Reasonable and Customary charges are NOT applied to the deductible or out-of-pocket maximum.
4. This is the maximum contribution members can make **after** GEO Academies' contribution which cannot exceed the federal limits of $3,850 for individuals or $7,750 for families.

Geo Foundation
Enrollment Verification # THA0001 - 143564

UMB Healthcare Services

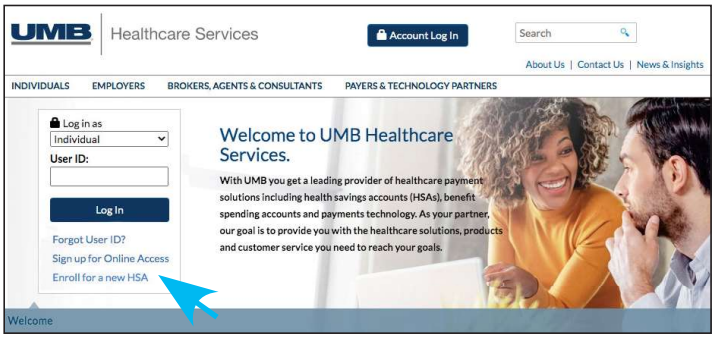
If you have enrolled in an HSA eligible health plan and want to sign up to contribute to an HSA, please use the following directions to get started. All HSA must be opened through UMB Healthcare Services. You must notify HR of the amount of your chosen deduction to be withheld from your pay. Additional educational items can be found at https://hsa.umb.com/individuals/education.

UMB HSA Online Enrollment Guide

Before you start, make sure you have the following required information available:

- Your physical address (you must have a physical address to open the account, but you may also enter a P.O. Box in "mailing address"), phone number, email address
- Your Date of Birth and Social Security number
- DOB & SS# for your spouse and/or dependents (age 18 or older) if requesting additional debit cards
- Employer verification code and program start date, provided by your employer

Note: You will not choose your beneficiary during enrollment. You will do this the first time you log on to your HSA.



Follow the six-step online enrollment process:

STEP 1: Enrollment Verification Number

Use the unique link provided by your employer, which will take you to Step 2, or go to **HSA.UMB.com** and click on "**Enroll for a new HSA**" and enter Enrollment Verification # provided by your employer.

STEP 2: Eligibility Requirements

Before proceeding, you will be prompted to confirm your eligibility to enroll in an HSA. This confirmation is performed by asking a series of questions. If you answer correctly based on the IRS requirements for eligibility, you will be able to proceed to Step 3.

STEP 3: Account Owner Personal Information

This step contains "sub-screens" that will capture all your personal information, verify your email address (UMB will send a code to your email), and allow you to input additional cardholders, if desired (spouse and/or dependents). **Note**: you must input a physical address to open your HSA or you will get an error message.

STEP 4: Review and Consent to Disclosures

In this step you will be required to open the disclosure documents and consent before you can continue. The documents will open in PDF format.

STEP 5: Verify & Submit Enrollment Information

You will be given a final opportunity to review all the information you typed in before your enrollment is transmitted to UMB for CIP review (Customer Identification Program, as required by Section 326 of the USA PATRIOT ACT, and UMB's CIP policy).

STEP 6: Confirmation

Based on the results during the session, you will get one of the following screens:

Complete Enrollment
The account is created (IF YOU GET THIS SCREEN, NO ADDITIONAL DOCUMENTATION IS REQUIRED).

Incomplete Enrollment
A message will appear indicating that UMB needs additional documentation from you (a copy of your social security card and driver's license) before we can open your account. The message provides three options (request a secure email link, fax or U.S. mail) for sending documentation copies to UMB.
Note: Your account will not be opened during this session. Your account will remain in pending status and unable to accept contributions until UMB receives the requested documentation and opens your account manually.

Once you have completed enrollment, within 5-7 business days you will receive two envelopes in the mail:

1. Your welcome letter with your account number, log on instructions, and additional information about your UMB HSA
2. HSA debit card including additional cards you ordered during your online enrollment session.

Once you receive your welcome letter, you may set up your online access, log in to your account and choose your beneficiary(s).

For questions or more information call 1.866.520.4HSA (4472).

Choosing Your Care: Bang for Your Buck!

We've all been there. Everything is going according to plan until life happens, and you or a family member is accosted by an unexpected illness or injury. In the panic and worry that follows, the only thing that comes to mind is doing whatever it takes to feel better—and fast! That panic can lead to a rush to get care without making an informed decision.

Educate yourself now when there is no urgent need! Making the wrong choice can result in delayed medical attention and may cost hundreds, if not thousands, of extra dollars. If you're faced with a sudden illness or injury, ask yourself:

What kind of care do I need?

- Routine? (visit to doctor's office)
- Urgent? (care that can't wait but isn't life-threatening)
- Emergency? (life-threatening need that requires immediate care)

How much money am I willing to spend to get that care?
If you have a life-threatening need, go to the ER. But if it's not life-threatening, would you rather find care that will cost less?

How convenient must my care be?
Maybe the ER is easier to find. Maybe you're used to a certain doctor. But if it's not an emergency, are you willing to go an extra mile to save substantial amounts of money?

After you've thought this through, decide which provider's "door" you want to use:

TELEMEDICINE	DOCTOR'S OFFICE	URGENT CARE	EMERGENCY ROOM
Common cold?	Sinus infection?	Broke your toe?	Cut off your arm?
Equipped to handle routine issues but does not require leaving the home to receive care	Equipped to handle routine issues that can be treated at home until appointment	Equipped to handle urgent injuries, illnesses and other medical conditions	Equipped to handle life-threatening injuries, illnesses and other medical conditions
TYPE OF CARE: Routine **COST:** $$ **CONVENIENCE:** Skype or FaceTime IN-HOME OPTION	**TYPE OF CARE:** Routine **COST:** $$$$ **CONVENIENCE:** Familiar; requires wait for availability	**TYPE OF CARE:** Urgent **COST:** $$$$$$ **CONVENIENCE:** Requires looking for facility	**TYPE OF CARE:** Emergency **COST:** $$$$$$$$$$$ **CONVENIENCE:** Easy to find; long waits

If you're not experiencing a life-threatening emergency, consider calling Teledoc! You will speak directly to a provider who can help answer your medical-related questions. The call is toll-free, confidential and the service is available anytime. Call 800-291-5837, website https://www.teledoc.com.

REMEMBER: While some options may be more cost-effective, they are **not** a substitute for emergency care. If it's an emergency, go to the ER!

Summaries above are generalizations; costs & convenience may vary.

Not sure what type of illnesses and injuries are classified as emergencies, urgent needs and/or routine care? This is not an all-inclusive "key," but it should help give you an idea. Again, if you have any question, assume it's an emergency. If it's not life-threatening, try calling Teledoc for further guidance, 800-291-5837.

EMERGENCIES

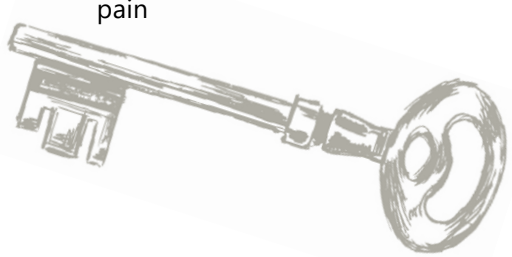
- Compound fractures
- Deep knife or gunshot wounds
- Moderate to severe burns
- Poisoning or suspected poisoning
- Seizures or loss of consciousness
- Serious head, neck or back injuries
- Severe abdominal pain
- Severe chest pain or difficulty breathing
- Signs of a heart attack or stroke
- Suicidal or homicidal feelings
- Uncontrollable bleeding

URGENT NEEDS

- Controlled bleeding or cuts that require stitches
- Ear infections
- High fever or the flu
- Minor broken bones (e.g. toes, fingers)
- Severe sore throat or cough
- Sprains or strains
- Skin rashes and infections
- Urinary tract infections
- Vomiting, diarrhea or dehydration

ROUTINE NEEDS

- Minor cuts and sprains
- Most fevers (<102°)
- Headache
- Sore throat
- Upper respiratory infection
- Common back and neck pain



Shop for Planned Care

Working with a doctor who has requested lab work or X-rays or some outpatient procedure? Usually, your doctor will recommend a place. Did you know that you do NOT have to go where your doctor refers you?

Why not shop for health care procedures the way you do for a new TV or a new car? Doing some research to find out the cost and quality of care for the same procedure at various locations can be a HUGE money saver! Healthcare Blue Book is a Transparency Tool to help you through this process. So, shop smart. Register at www.unifiedgrp.com and this tool will be available to you.

Did you know that some health care providers are not In-Network providers?

To get the most bang for your buck when seeking unexpected or planned care, you want to make sure you go to an in-network provider! While these providers aren't always as easy to identify as the color-coded images below, it's fairly easy to determine. You can find a list of in-network providers by going to your medical, dental and/or vision carrier's website or by calling the number on the back of your insurance card.

You can also call and ask your doctor! The benefits of seeking in-network care (instead of out-of-network) include less cost for service, no chance for billing you the balance of what your insurer does not pay and no chance of having to fill out additional claims paperwork. Less money and less stress? It's the way to go!

Additional Benefit Offerings

Teladoc

Discover new ways to connect with health care professionals. Telemedicine (Teladoc) is an alternative to in-person doctor visits, using technology to connect you to providers who can evaluate, diagnose, and treat you from a distance. It's a great alternative to the emergency room and costs much less. It's also convenient, especially if you live in an area where urgent care facilities aren't easily accessible.

The General Medical component of Teladoc is commonly utilized for sinus problems, UTI, pink eye, bronchitis, ear infection, and more. Generic prescriptions are recommended when a prescription is deemed necessary. Teladoc does not prescribe DEA controlled substances.

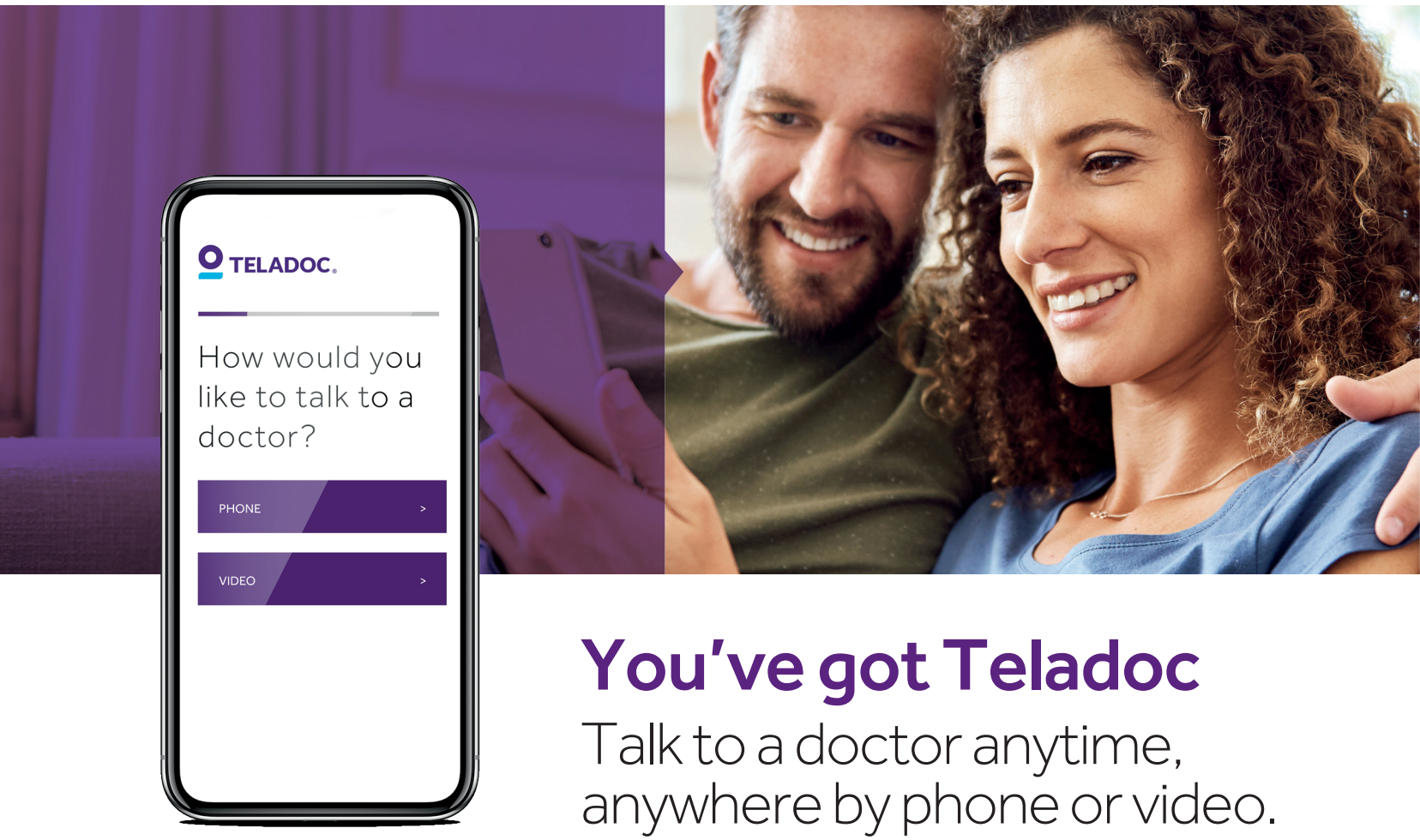
Dermatology coverage is available. Members can treat acute or ongoing skin conditions like psoriasis, skin infections, rosacea, and more. Simply share images via Teladoc and receive a diagnosis within two business days (on average 8 hours). Access to the dermatologist is available for follow-up within seven days. Providers can prescribe approved medications when necessary.

HDHP: General Medical- $55 Copay
PPO: General Medical- $30 Copay
Get started with Teladoc TODAY! I **800.291.5837** https://www.teladoc.com/
You will receive a **$50 check** about a month after you set up your Teladoc account!

Follow these steps to set up your account:

1. Search for "Teledoc" in the App Store or on Google Play. You also visit www.unifiedgrp.com and visit the Teledoc link on your account from your computer.
2. Select "Set up your account."
3. Provide information about yourself to confirm your eligibility. Pick your health plan from the dropdown menu and enter your health plan ID.
4. Enter your address and phone number, create a username and password, agree to terms and conditions.

TELADOC. | GEO FOUNDATION WHERE ALL ROADS LEAD TO COLLEGE PPO



You've got Teladoc

Talk to a doctor anytime, anywhere by phone or video.

Set up your account today to talk to a U.S.-licensed physician for non-emergency medical conditions like the flu, sinus infections, bronchitis, and much more.

Create account

Use your phone, the app, or the website to create an account and complete your medical history

Talk to a doctor

Request a time and a Teladoc doctor will contact you

Feel better

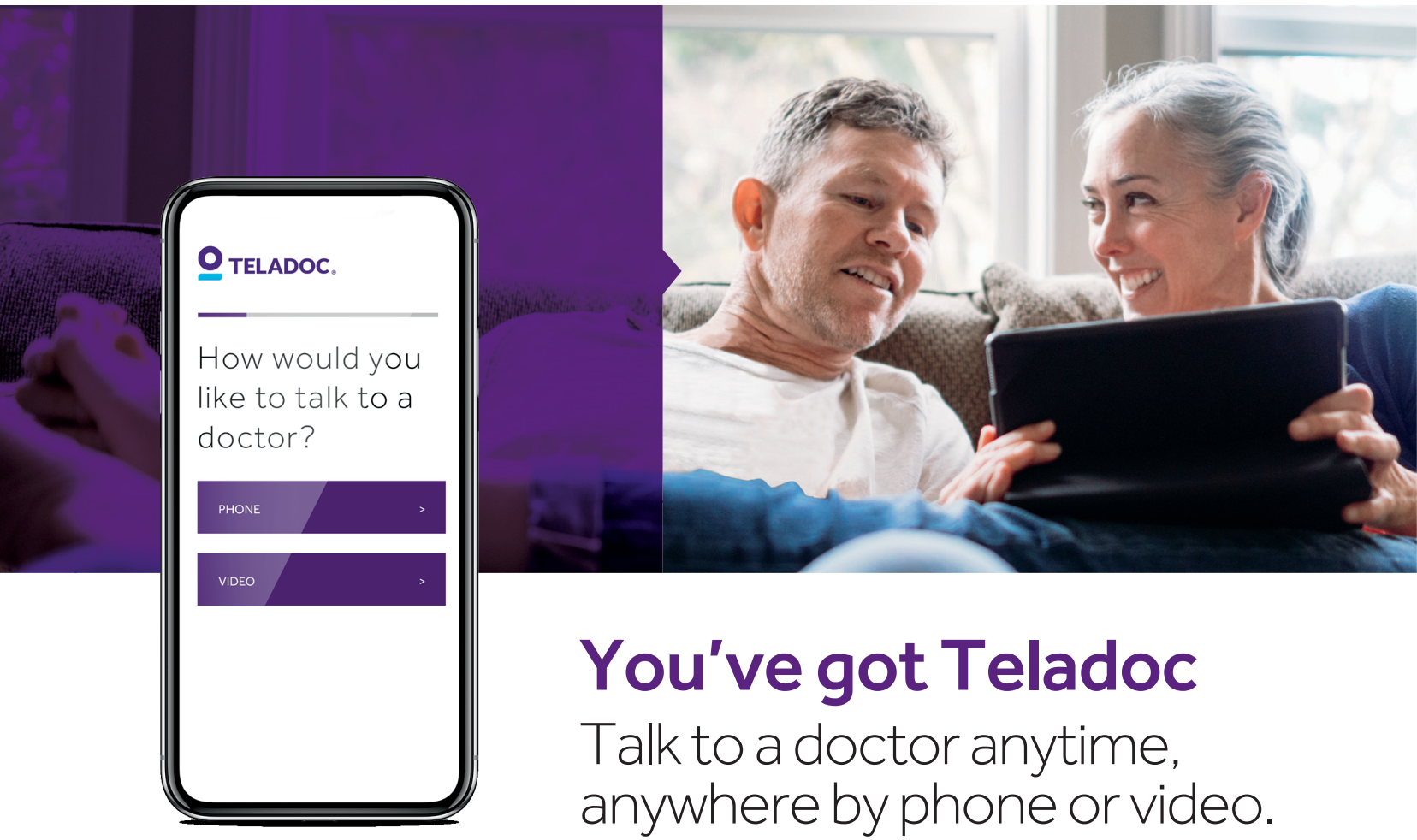
The doctor will diagnose symptoms and send a prescription if necessary

Talk to a doctor for $30

Call 1-800-TELADOC (835-2362) | Visit Teladoc.com

Download the app

TELADOC. | GEO FOUNDATION WHERE ALL ROADS LEAD TO COLLEGE HDHP



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Create account

Use your phone, the app, or the website to create an account and complete your medical history

Talk to a doctor

Request a time and a Teladoc doctor will contact you

Feel better

The doctor will diagnose symptoms and send a prescription if necessary

Talk to a doctor for $55

Call 1-800-TELADOC (835-2362) | Visit Teladoc.com

Download the app

Additional Benefit Offerings

Healthcare Bluebook

What is Healthcare Bluebook?

Healthcare Bluebook is included with each medical plan. Healthcare Bluebook's purpose is to protect patients by exposing the truth about price and quality variation, and empowering patients to make informed decisions. Shopping for a car or a new phone is easy. Shopping for healthcare is not. Healthcare Bluebook solves this problem by providing an intuitive, easy to use web and mobile platform that enables patients to look up services and compare providers on cost and quality. Knowing price and quality before receiving care can save you hundreds or even thousands of dollars and ensure that you receive the best possible care.

What does Bluebook do?

Healthcare Bluebook helps you save money on healthcare services. Did you know that in-network prices for the same procedure can vary by over 500%, depending on the facility you choose? Their web and mobile applications make it easy to save money on hundreds of the most common medical services and procedures by showing you the cost ranges in your area and providing you with a selection of Fair Price providers.

What is the "Fair Price?"

The Fair Price is the price that a person can expect to pay by being a prudent healthcare consumer: someone who does basic research to determine which facilities offer the best price for a specific service. Bluebook Fair Prices are based on the actual amount paid on the claim, not the billed amount, and reflect the discounts that the health plan has negotiated with the facility. For services that include more than one provider, separate Fair Price amounts may be shown for

Tips For Receiving the Best Price

- Doctors often perform procedures at multiple facilities. **Search for your doctor in Healthcare Bluebook** to see which facilities they typically use and if one of those facilities is a Fair Price™ facility.
- Sometimes your doctor will recommend or make a referral to a doctor or facility near you. Before receiving care at the facility, call or check Bluebook to confirm the facility charges a Fair Price for the test. If the facility does not charge a Fair Price, ask your doctor if they can make a referral to another facility that has Fair Prices.
- Providers can and do change network status regularly. Before seeking treatment, we recommend that you call the provider to verify they are currently in your network and their current price. Healthcare Bluebook does not guarantee provider prices.
- If your procedure is a surgery, remember that surgery prices are typically composed of three components, 1) hospital or facility, 2) surgeon and 3) possibly anesthesia. The hospital or facility fee is most often the component with the largest price variation. You will want to inquire about all three components as you evaluate providers for your procedure.

Healthcare Bluebook™

Unified Group Services

Your employer provides **Healthcare Bluebook** FREE as a benefit, so you can shop for medical procedures at in-network facilities in your area to find the best price and get an out-of-pocket cost estimate. It's easy!

In minutes, you can find hundreds to thousands of dollars in savings with a simple search and get a cost estimate before you schedule care.

What is a Fair Price?

A Fair Price is the reasonable amount you should expect to pay for a procedure or medical service.

Check out the reverse side for an example of dramatic price differences and out-of-pocket cost estimate.

1 LOGIN AND FIND A FAIR PRICE!

Scan the QR code with your phone or use the link below to access **Healthcare Bluebook**.

unifiedgrp.com

Your mobile code = unified

2

Search for your medical procedure to access price information as well as a list of in-network facilities in your area. Use the green, yellow, and red color signs to guide you to **Fair Price™** (green) facilities.

COST RATINGS	$	$$	$$$
	At or Below Fair Price	Slightly Above Fair Price	Highest Price

3 GET A COST ESTIMATE

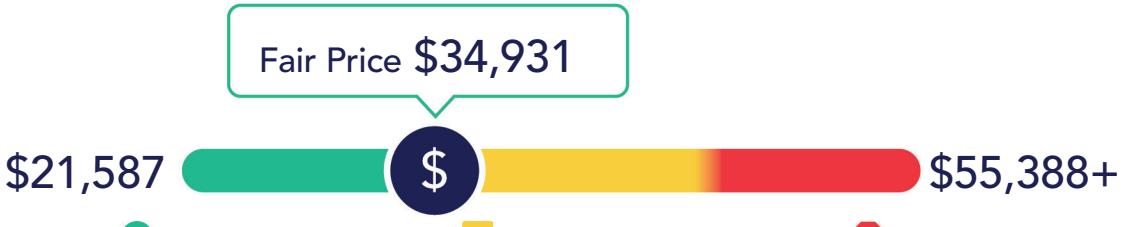
Select a **Fair Price™** (green) facility and you'll see your estimated out-of-pocket cost pertaining to the selected in-network facility as well as details correlated to your deductible.

Healthcare Bluebook™

Below you'll see an example of the huge price differences for the same procedure depending on where you go for care and a sample of an out-of-pocket estimate.

Bluebooks simple guides make it easy to navigate to in-network medical facilities in your area to find affordable healthcare and out-of-pocket costs.

Total Knee Replacement



GO HERE
- XYZ Best Quality Hospital (~ 2 miles)
- XTRA Memorial Hosp (~ 3 miles)

NOT HERE
- Too Much Medical Center (~ 1 mile)

Example out-of-pocket cost estimate

The average price for Total Knee Replacement with these providers: **$23,302**

Vanderbilt University Hospital

Your estimated out of pocket for this procedure: **$3,000**

Out of Pocket Balances:

Individual deductible **$3,000** maximum:
$1,000 spent — **$2,000** remaining

Individual out-of-pocket **$4,000** maximum:
$1,000 spent — **$3,000** remaining

Family deductible **$6,000** maximum:
$2,000 spent — **$4,000** remaining

Family out-of-pocket **$8,000** maximum:
$2,000 spent — **$6,000** remaining

See more procedures and costs for in-network providers by logging onto Healthcare Bluebook.

Unified Group Services

Mobile Code: unified
unifiedgrp.com
(765) 608-6680

DON'T BREAK A SWEAT TRYING TO BREAK A SWEAT.

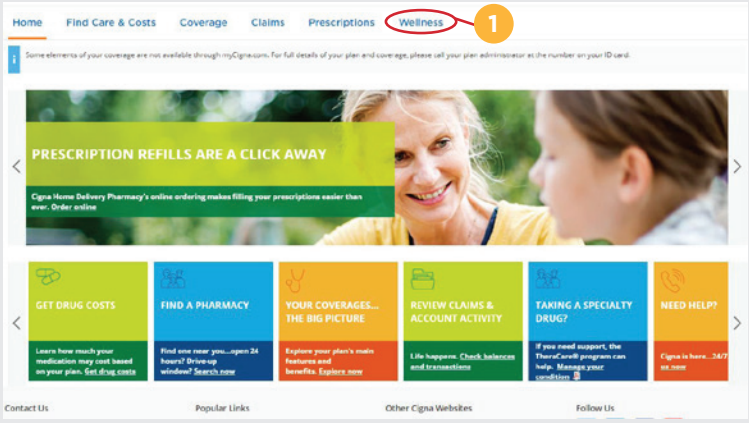
Simple steps to get to your fitness discounts.

Ready to work out? We'll make getting there the easy part.

The Cigna Healthy Rewards® program* offers you access to a number of discounts on health programs and services, including gym memberships.

Where can you find more information? Start by logging in to **myCigna.com** and then follow this guide:

1. Click on the **"Wellness"** tab at the top right side
2. Select **"Exercise" or "Weight"**



Together, all the way.®

Cigna®

917050 b 08/22

3 Scroll down to **“Healthy Rewards”**

4 Click on **“Gym Memberships & Digital Workouts – Start Savings”**

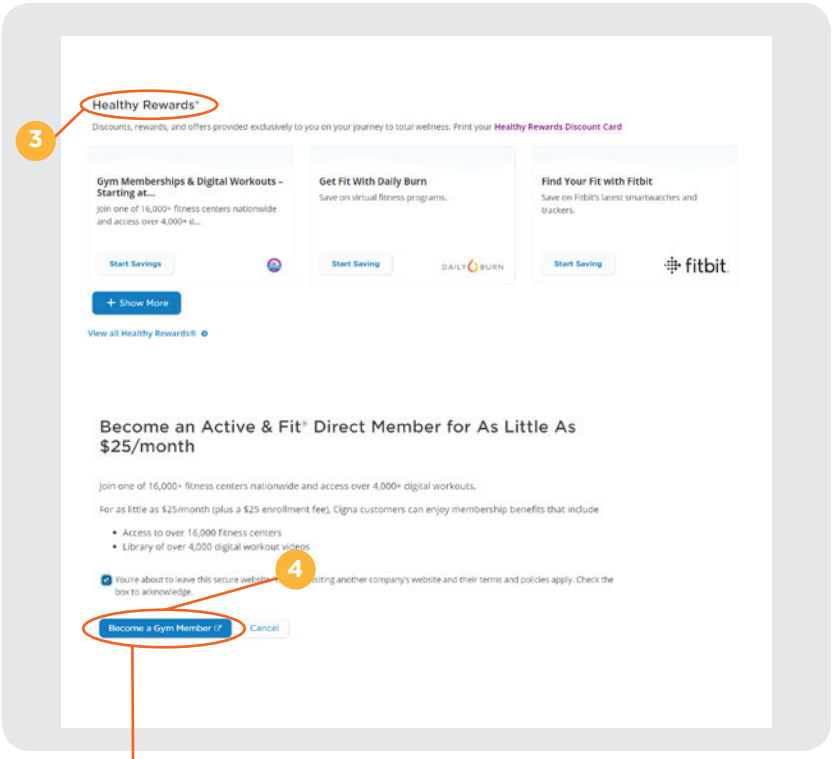
You’re there!

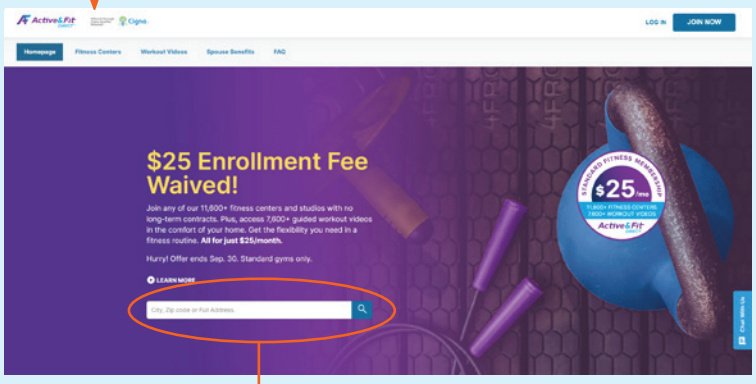
The updated **Active&Fit Direct**™ page takes the heavy lifting out of finding a local gym and accessing your discounted membership. And did we mention memberships are only **$25 per month.****

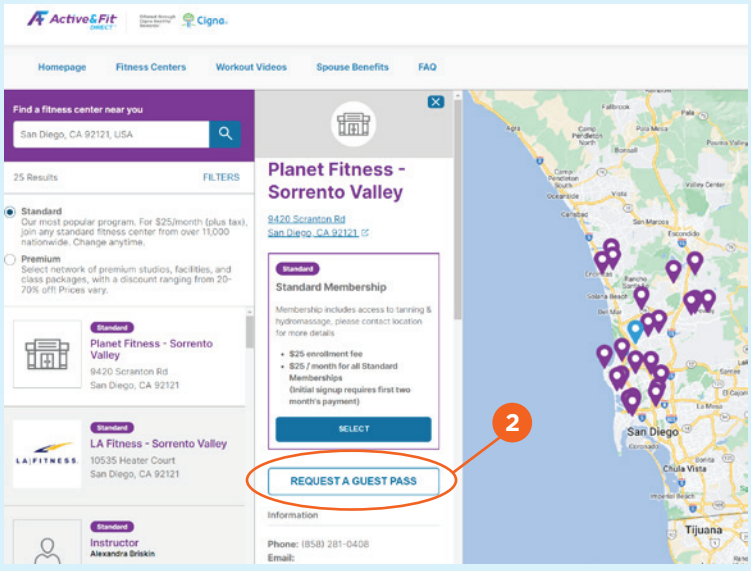
From the home page, you can:

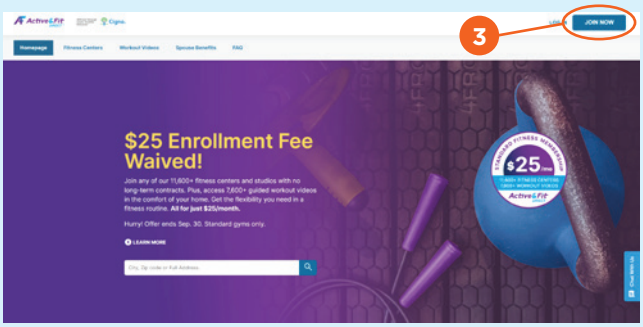
1 Find a local gym by your zip code or city/state and get details on the facility.

2 Not ready to enroll? Click **“Request Guest Pass Letter”** in your search results, create an account and then print your guest pass.

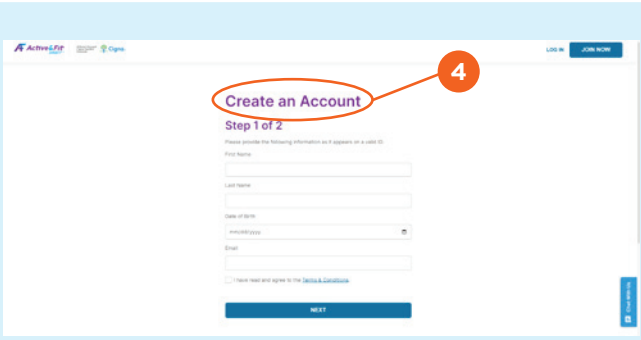






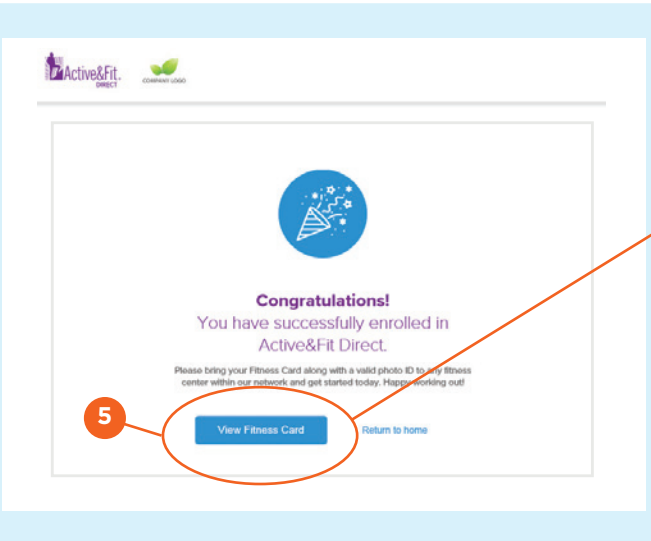


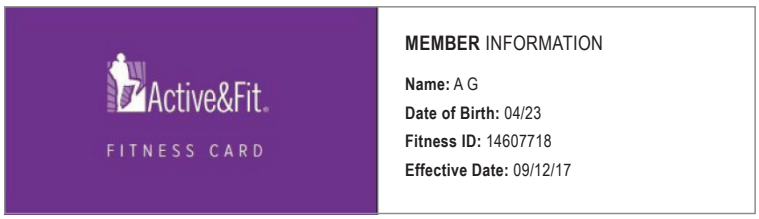
3 If you're ready to get your discounted membership, select **"Join Now."** You'll create an account if you didn't already, provide payment information and print your fitness card to take to your new gym.



4 Enter both your personal and payment information here.

5 Now, just click to view your card, print it out and take it with you to your new gym.





Go to myCigna.com to kick-start your health.

Cigna®

*** Healthy Rewards is a discount program and is NOT insurance.** This program is separate from your medical plan benefits. You are required to pay the entire discounted charge. Always consult your doctor prior to beginning a new exercise program. Your participation in this program may be subject to program terms and conditions and is at your sole risk.

** Plus a $25 one-time enrollment fee and applicable taxes.

The Active&Fit Direct program is provided by American Specialty Health Fitness, Inc. (ASH), an independent company/entity and a subsidiary of American Specialty Health Incorporated. ASH is not affiliated with Cigna and is solely responsible for the Active&Fit Direct program. Active&Fit Direct, Break a Sweat Without Breaking the Bank, and the Active&Fit logos are trademarks of American Specialty Health, Incorporated. As to American Specialty Health content/properties, (c) 2017 American Specialty Health.

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Prescription Drugs

All medical plans include coverage for prescription medication. GEO Academies' program is coordinated through **TrueRx**.

Prescription

	Hybrid PPO Option 1		HSA Qualified Option 2		HSA Qualified Option 3	
Tier	**In Network Retail**		**In Network Retail**		**In Network Retail**	
Generic	$10 Copay		Deductible, 20%		Deductible, 20%	
Brand	$40 Copay		Deductible, 20%		Deductible, 20%	
Non-Preferred	$60 Copay		Deductible, 20%		Deductible, 20%	
Specialty	Not covered		Not covered		Not covered	
	Hybrid PPO Option 1		**HSA Qualified Option 2**		**HSA Qualified Option 3**	
Tier	**Out-of-Network Retail**	**Mail Order**	**Out-of-Network Retail**	**Mail Order**	**Out-of-Network Retail**	**Mail Order**
Generic	$10 Copay	$25 Copay	Deductible, 50%	Deductible, 20%	Deductible, 40%	Deductible, 20%
Brand	$40 Copay	$100 Copay	Deductible, 50%	Deductible, 20%	Deductible, 40%	Deductible, 20%
Non-Preferred	$60 Copay	$150 Copay	Deductible, 50%	Deductible, 20%	Deductible, 40%	Deductible, 20%
Specialty	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
			Coinsurance applies **after** deductible (Combined with medical)		Coinsurance applies **after** deductible (Combined with medical)	

True RX Health Strategists

Employee's that participate in a GEO medical plan, automatically receives prescription coverage. True RX offer's pharmacy pick up and mail delivery. You can find the cost of a medication on the TrueRx App and compare prices at multiple pharmacies in your area. You can view your deductible and more based upon your medical plan.

RX Help Centers

A program that works to fill the common and costly voids that are often found in prescription benefit plans. This program works with reputable pharmaceutical companies to get you maximized prescription savings based on your personal needs. Receive a $100 check for your first qualified prescription through Rx Help Centers! This offer is available to all members of GEO's health plan. Included with each medical plan, paid for by GEO.

Simply call 866-478-9593 or go online to http://rxc8290368-geoacademies.rxhelpcenters.com.

GEO Foundation

2024 Prescription Drug Benefits

TrueRx - Pharmacy Benefit Manager: They will administer your prescription drug plan.

Phone (866)921.4047 Website: TrueRx.com

RxHelp Centers - Prescription Drug Assistance Program: The program may assist you in obtaining high cost brand name drugs and also all specialty drug prescriptions at little or not cost to you.

RxHelp Centers Website - http://rxc8290368-geoacademies.rxhelpcenters.com

Phone (866)478.9593

Williams Brothers Specialty Pharmacy - Preferred Specialty pharmacy: Will assist you initially with any specialty drug prescriptions until RxHelp Centers is able to cover.

How does the RxHelp Centers application process work?

If you are taking a Specialty drug that is treating a diagnosis that is covered under your then TrueRx or Williams Brothers Pharmacy will reach out to you and direct you to contact RxHelp Centers and explain the process.

If you are taking a brand name or generic drug and want to apply for RxHelp Centers then you will need to either use the web link provided above, call RxHelp Centers, or fill out the paper application.

What is the next step in the RxHelp Centers process?

Once RxHelp Centers receives your information they will reach out to you via email or phone in a few days. RxHelp Centers could need additional information to complete the application, which could include income verification or simply additional signatures.

Do I have to wait to get my Specialty prescription while this process goes on?

No, TrueRx and Williams Bros. Pharmacy will be able to fill your prescription while your application is still in process. However, specialty drugs will not be covered unless you apply with RxHelp Centers and provide them all of the requested information. An initial 30 day fill will be covered but thereafter you must utilize RxHelp Centers for specialty drug fills.

What if I get denied FREE assistance?

There are two options with Rx Help Centers process. The first will be FREE assistance through a Patient Assistance Program and this is an application process. The second option is mail order. If member is denied or does not qualify for first option then the Rx Help Centers represenative will work with member to set up a mail order option. This will be sent directly to member and will be a set up with 90 day supply.

Dental

GEO Academies aims to help promote your hygiene health by offering dental insurance through Unified Groups Services utilizing the **Cigna network**. Most dental plans allow you to choose which dentist you see–going to an in-network dentist will help save you money.

To find out if your dentist is in-network, go to www.cignadental.com.

Details	Cigna Network
	Core Dental Plan
Deductible	
Individual	$50
Family	$150
Annual Plan Payment Maximum	
Individual	$1,500
Preventive Services	Deductible does not apply
Coverage rates for diagnostic & preventive services, emergency palliative treatment, sealants, brush biopsy and radiographic	100%
Basic Services	Deductible applies
Coverage rates for minor restorative services, endodontic services, periodontal services, oral surgery services, other basic services and relines and repairs	80%
Major Restorative Services	Deductible applies
Coverage rates for major restorative services and prosthodontic services	50%
Orthodontia	
Individuals Covered	**Eligible children up to age 19**
Lifetime Payment Maximum	$1,500 per individual
Coverage Rate	50%

*When you receive services from a non-participating dentist, the percentages in this column indicate the portion of Dental's Non-Participating Dentist Fee that will be paid for those services. The Non-Participating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

Premiums	
	Per Payroll
Tier of Coverage	
Employee Only	$3.25
Employee + Spouse	$19.00
Employee + Child(ren)	$27.00
Family	$43.00

Vision

GEO Academies wants to help protect the health of your eyes, that's why we provide vision insurance from VSP through **Kansas City Life**.

To find out if your eye doctor is in-network, go to www.kclgroupbenefits.com/Vision. If you go out-of-network, you will notice the details below show an "up to" amount. This is because you must pay the full cost of the service out of pocket, and then the insurance plan will reimburse you "up to" the defined amount. Look at your plan details for information on how to file for reimbursement.

Details

	Vision Plan Option from VSP through Kansas City Life		
	In-Network	**Out-of-Network**	**Frequency**
Exam	$10 Copay	Up to $45 allowance	Once every 12 months
Frames	$130 allowance + 20% off remaining balance	Up to $70	Once every 24 months
Lenses			
Single	$25 Copay	Up to $30	Once every 12 months
Bifocal	$25 Copay	Up to $50	
Trifocal	$25 Copay	Up to $65	
Lenticular	$25 Copay	Up to $100	
Contact Lenses (in lieu of glasses)			
Medically Necessary	$25 copay; paid in full	Up to $210	Once every 12 months
Elective (Disposable)	$25 copay; up to $130 allowance	Up to $105	
Additional Benefits			
Second Pair Discount	20% off additional pairs of glasses or sunglasses		
Lasik or PRK from US Laser Network	15% off retail price or 5% off promotional price Discounts only available from contracted facilities.		

Premiums

	Per Payroll
Tier of Coverage	
Employee Only	$3.83
Employee + 1	$6.45
Employee + Child(ren)	$6.58
Family	$10.62

Disability Insurance

A great way to protect your paycheck should something happen is to invest in disability insurance. Here are some details of what's available to you:

	Benefit Eligible Employees	
	Short Term Disability (STD) Options from Kansas City Life	**Long Term Disability (LTD) Options from Kansas City Life**
Do I qualify for this benefit?	This benefit is available for all active FT employees working 30 hours or more per week.	This benefit is available for all active FT employees working 30 hours or more per week.
What percent of my paycheck will be covered?	At least $150 per week, elected in $25 increments, not to exceed 60% of weekly earnings.	60% of monthly earnings
What is the maximum amount I'll be paid?	$1,000 weekly	$6,000 monthly
Is there a waiting period before benefits are paid?	Yes – 0 days for an accident; 7 days for an illness.	Yes – 90 days
Is there a pre-existing condition exclusion?	Yes – benefits will not be paid for a disability caused by an existing condition for which you received care within 3 months before your enrollment date and will not be paid for the first 12 months after your enrollment date.	Yes – benefits will not be paid for a disability caused by an existing condition for which you received care within 3 months before your enrollment date and will not be paid for the first 12 months after your enrollment date. Yes
Will tax be deducted from my monthly benefit?	No, since you are paying for this premium, the IRS will not consider this as taxable income.	Yes, since GEO Academies is paying for this premium, the IRS will consider this as taxable income.
How does my PTO and accrued vacation time tie into this wait?	All accrued PTO time must be exhausted during a leave of absence before utilizing unpaid status.	Since there is a longer waiting period before the LTD benefits begin, there should be no overlap with your PTO or Vacation time.
Does this benefit pay if I'm also claiming Worker's Comp?	No – you cannot claim Worker's Comp and STD benefits at the same time.	No – you cannot claim Worker's Comp and LTD benefits at the same time.

How Much Voluntary Short Term Disability Costs…

Since STD protects your earnings and most people's earnings are different, it makes sense that the cost to purchase this protection varies from person to person. While the following looks complicated, it's not. Use the chart below to determine your rate and the equation below to determine how much you will pay per month. **If your benefit amount is not the total of 60% of salary – start with the box labeled Weekly Benefit to determine your monthly cost.**

Short Term Disability Rates per $10 Weekly Benefit			
Age Band / Rate			
Under 25 / $0.60	35-39 / $0.55	50-54 / $0.58	65-69 / $0.92
25-29 / $0.70	40-44 / $0.48	55-59 / $0.67	70+ / $0.97
30-34 / $0.71	45-49 / $0.49	60-64 / $0.79	

TO CALCULATE HOW MUCH YOUR STD COVERAGE WILL COST:

$	÷52=	$	x .60	$	÷10=	$	x	$	=	$
Annual Salary		Weekly Earnings	(benefit %)	Weekly Benefit				Rate based on Age Band		Monthly Cost

Additional Benefit Offerings

Reliance Standard

Reliance Standard Group Term Life Insurance is available to all eligible full-time employees, as described by GEO. GEO provides basic group term life coverage in the amount of $20,000.

Voluntary Group Critical Illness Insurance helps you and your family maintain financial security during the lengthy, expensive recovery period after an illness has been diagnosed. It provides a lump-sum benefit to help with out-of-pocket medical costs or everyday expenses. $50 annual wellness benefit.

Voluntary Supplemental and Life insurance GEO continues to offer numerous voluntary insurance options to assist you and your family and are managed by Reliance Standard. During enrollment, you can elect your supplemental life coverage without answering health questions. Elections above the amounts listed by Reliance, or outside of your enrollment event, will require you to demonstrate your good health, also known as evidence of insurability (EOI).

Voluntary Accident Insurance is an indemnity plan providing employees and their families with injury, hospital, doctor, accidental death, and catastrophic accident benefits in the event of a covered accident. These benefits can help with the out-of-pocket medical and non-medical expenses associated with an accident. A covered accident can occur on or off the job and still be covered. Benefits are payable directly to the insured. $50 annual wellness benefit.

Voluntary Medical Bridge Reliance Standard's hospital indemnity insurance plan offers a solution for individuals that have been confined to the hospital due to a covered accident or illness. This coverage provides flexibility on how you spend the benefit dollars. You can use it to offset deductibles, co-pays, and out-of-pocket medical. Or you may choose to pay bills, buy groceries or anything for which you may need the money.

Voluntary Atlantic American Whole Life Insurance plan is individually owned, with guaranteed level premiums, guaranteed cash values and a guaranteed death benefit. Coverage is permanent and is guaranteed for the life of the policy (to age 100), provided premiums are paid when due. Coverage is available for employees, spouses, children and or grandchildren.

Reliance Standard Value Added is a valuable Online Resource for Policyholders. Policyholders can connect with Reliance Standard for fast and easy service online. The website allows policyholders to manage their benefits online. Policyholders save time and reduce paperwork by registering and confirming electronic consent (e-Consent). Providing e-Consent allows policyholders to access policy documents and to file claims online.
Go to https://secure.rsli.com/userservices/ to register.

Plan Highlights

Group Basic Life / AD&D Insurance

Geo Academies

ELIGIBILITY

As Defined by the Employer.

BENEFIT AMOUNT

Basic Life and AD&D: $20,000

GUARANTEED ISSUE

$20,000

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employer Paid.

AD&D SCHEDULE

For Accidental Loss of	Amount Payable
Life	100%
Both Hands	100%
Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing	100%
One Hand	50%
One Foot	50%
Sight of One Eye	50%
Speech	50%
Hearing	50%

BENEFIT REDUCTION DUE TO AGE

Age	Original Benefit Reduced to
65	65%
70	40%
75	20%

FEATURES

- Accelerated Death Benefit
- Air Bag Benefit
- Conversion Privilege
- FMLA/MSLA Extension
- Portability
- Seat Belt Benefit
- Waiver of Premium

VALUE-ADDED SERVICES

- Bereavement Counseling Services
- Travel Assistance Services

Plan Highlights

Group Supplemental and Dependent Life Insurance

IMPORTANT! During this open enrollment, employees with existing coverage, or a late enrollee are able to add or get $50,000 of coverage on a guaranteed issued basis and spouses can add or get $10,000 of coverage not to exceed the maximum guaranteed issue amounts of $150,000 for employees or $25,000 for spouses.

ELIGIBILITY

As Defined by the Employer.

Dependents: You must be insured for your Dependents to be covered.

Dependents are:

- Your legal spouse who is not legally separated or divorced from you;
- Your unmarried financially dependent children birth to 26 years;
- A person may not have coverage as both an Employee and Dependent;
- Only one insured spouse may cover dependent children.

BENEFIT AMOUNT

Supplemental Life: Choose from a minimum of $10,000 to a maximum of $500,000 in $10,000 increments.

Spouse: Choose from a minimum of $10,000, a maximum of $500,000 in $5,000 increments, not to exceed 100% of employee amount.

Child(ren): Birth to age 26 years: $10,000.

GUARANTEED ISSUE

Initial eligibility period only

Employee:

Under age 60: $150,000

Age 60 but less than age 70: $150,000

Age 70 and over: $10,000

Spouse:

Under age 60: $30,000

Age 60 but less than age 70: $30,000

Age 70 and over: $30,000

Child(ren): $10,000

Geo Academies

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employee Paid.

BENEFIT REDUCTION DUE TO AGE

Age	Original Benefit Reduced to
65	65%
70	40%
75	20%

FEATURES

- Accelerated Death Benefit
- Conversion Privilege
- FMLA/MSLA Extension
- Portability
- Waiver of Premium

ATLANTIC AMERICAN
Employee Benefits

GROUP WHOLE LIFE INSURANCE

and Living Care Benefits

IMPORTANT! **During this open enrollment period, you may elect whole life insurance up to the guarantee issue amount.**

Give yourself protection for a lifetime

Many people buy life insurance to provide financial protection for those left behind. What if your life insurance could also provide benefits if you suffer from a permanent health condition and you require ongoing care from a family member or professional caregiver?

Value of Whole Life insurance

- Permanent Life insurance
- Living Care benefits for chronic illnesses
- Guaranteed premiums and death benefits
- Accumulates cash value[1]
- Payroll-deducted premiums
- Coverage can be taken with you if you change jobs or retire, billed directly to you at home

Atlantic American's Whole Life & Living Care plan combines the guarantees of permanent life insurance with the benefits of living care protection. Our living care benefits can assist you when you need to take care of ongoing expenses that arise from a chronic medical condition.

This hybrid life product is ideal if you want to:

- Leave a death benefit to loved ones after you die
- Provide benefits for the costly expenses associated with care, particularly over long periods of time
- Lifelong coverage through retirement with no increase in premiums

How can Living Care benefits help?

- Adult daycare
- Assisted living or nursing home
- Prescription drugs
- Gas for transportation (to and from treatment)
- Cash to a family member to assist in your care

[1]Access to cash values through borrowing or partial surrenders will reduce the policy's cash value and death benefit, increase the chance the policy will lapse, and may result in a tax liability if the policy terminates before the death of the insured.

Plan Highlights

Voluntary Group Critical Illness Insurance

IMPORTANT! You may elect or add this benefit during open enrollment.

Geo Academies

COVERAGE

Voluntary group critical illness insurance provides a fixed, lump-sum benefit upon diagnosis of a critical illness, which can include heart attack, stroke, paralysis and more. These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and child care.

ELIGIBILITY

As Defined by the Employer.

Dependents: You must be insured for your Dependents to be covered. Dependents are:

- Your legal spouse. Spouse must be under age 70 at date of application. Coverage terminates at age 75.
- Your dependent children from birth to 26 years.
- A person may not have coverage as both an Employee and Dependent.

BENEFIT AMOUNT

Employee: Choose from a benefit of $5,000 to a maximum of $20,000 in $5,000 increments.

Spouse: Choose from a benefit of $5,000 to a maximum of $20,000 in $5,000 increments, not to exceed 100% of approved employee amount.

Child(ren): 50% of approved employee amount up to a maximum of $10,000.

GUARANTEED ISSUE

Employee: $20,000
Spouse: $20,000
Child(ren): $10,000

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employee Paid.

RATES

See attached Rate Sheet

FEATURES

DIAGNOSIS ADULT	BENEFIT
Alzheimer's Disease	100%
Benign Brain Tumor	100%
Carcinoma In Situ	25%
Coma	100%
Coronary Disease	50%
Heart Attack	100%
Life Threatening Cancer	100%
Loss of Hearing	100%
Loss of Sight	100%
Loss of Speech	100%
Major Organ Failure	100%
Motor Neuron Disease (ALS)	100%
Paralysis	100%
Parkinson's Disease	100%
Skin Cancer	5%
Stroke	100%
DIAGNOSIS CHILD	**BENEFIT**
Cerebral Palsy	100%
Cleft Lip or Palate	100%
Cystic Fibrosis	100%
Downs' Syndrome	100%
Muscular Dystrophy	100%
Spina Bifida	100%
Type 1 Diabetes	100%

- Lifetime Maximum Benefit – 1000% of Insurance Amount
- Subsequent Occurrence Benefit – 100% of benefit if diagnosed 0 months or later
- Recurrence Benefit (Same Illness) – 100% of benefit if diagnosed 6 months or later
- Portability to employee age 70
- **Wellness (Health Screening) Benefit – $50**

Reliance Standard Voluntary Plans
Critical Illness Insurance
Premium Table

Plan Holder: Geo Academies

Scheduled Benefit:

Each eligible employee may elect for himself and/or his eligible spouse an amount of insurance shown in the table below.

Employee/Spouse Premiums:

To find you and your spouse's premium -

- Determine your age band:
  - Your age = your age at your last birthday.
  - Spouse age = your age at your last birthday.
- Select a benefit from:
  - Select an employee and spouse benefit from the table below.
- Employee and spouse rates change as insured moves from one age bracket to the next, based on the age determination rules.

Employee and Spouse Semi-Monthly Premiums

Benefit Amount	Age 0-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70-74	Age 75-79	Age 80-84	Age 85+
$5,000	$0.70	$1.18	$1.48	$2.10	$3.30	$4.70	$6.60	$9.85	$14.78	$24.33	$40.88	$56.63	$94.38
$10,000	$1.40	$2.35	$2.95	$4.20	$6.60	$9.40	$13.20	$19.70	$29.55	$48.65	$81.75	$113.25	$188.75
$15,000	$2.10	$3.53	$4.43	$6.30	$9.90	$14.10	$19.80	$29.55	$44.33	$72.98	$122.63	$169.88	$283.13
$20,000	$2.80	$4.70	$5.90	$8.40	$13.20	$18.80	$26.40	$39.40	$59.10	$97.30	$163.50	$226.50	$377.50

Dependent Child(ren):

Your dependent child(ren) is eligible for a benefit amount of 50% of your Critical Illness benefit election, limited to a maximum of $10,000.

Child(ren) rate is included in the Employee Rates above.

Please Note: One rate and benefit amount for all eligible children in family, regardless of number.

Please read this important information

- You may not have coverage as both an employee and as a dependent.
- Employee must have coverage in order for spouse and dependent children to be covered.

Please note, these rates are approximate and subject to change.

Plan Highlights

Voluntary Group Accident Insurance

IMPORTANT! During this open enrollment period you may elect to enroll in Accident Insurance.

Geo Academies

COVERAGE

Voluntary group accident insurance provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident, or for accidental death and dismemberment (if included). These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and childcare.

ELIGIBILITY

As Defined by the Employer. Employee must be under age 70 to enroll.

Dependents: You must be insured for your Dependents to be covered. Dependents are:

- Your legal spouse. Spouse must be under age 70 at date of application.
- Your dependent children from birth to 26 years.
- A person may not have coverage as both an Employee and Dependent.

BENEFIT AMOUNT

See Full Schedule of Benefits on next page

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employee Paid.

SEMI-MONTHLY PREMIUM

Coverage	Plan A	Plan B
Employee	$ 4.29	$ 6.40
Employee and Spouse	$ 6.28	$ 9.83
Employee & Children	$ 7.10	$ 12.35
Employee & Family	$ 9.41	$ 16.09

FEATURES

- Portability - Unlimited or when Employee Retires
- FMLA/MSLA Continuation
- Newlywed and Newborn Provision
- 24-Hour Travel Assistance Services
- Off the Job Coverage

Benefits	Plan A	Plan B
Ambulance	$100 Ground, $500 Air	$300 Ground, $1,500 Air
Blood, Plasma and Platelets	$200	$450
Burns	To $800 for 2nd degree burns; To $6,400 for 3rd degree burns; Skin Graft - 25% of benefit payable for Burns	To $1,600 for 2nd degree burns; To $12,800 for 3rd degree burns; Skin Graft - 50% of benefit payable for Burns
Chiropractic Services (per Visit)	$25 per session, 6 sessions maximum	$37.50 per session, 6 sessions maximum
Coma	$5,000	$10,000
Concussion	$100	$200
Dental Injury	$150 for Crown; $50 for Extraction	$300 for Crown; $100 for Extraction
Diagnostic Exams	$100 per CT/MRI scan	$200 per CT/MRI scan
Dislocation	To $1,600 for Non-surgical; To $3,200 for Surgical; Partial - 25% of full dislocation; Multiple - 100% of highest dislocation benefit	To $3,600 for Non-surgical; To $7,200 for Surgical; Partial - 50% of full dislocation; Multiple - 200% of highest dislocation benefit
Emergency Treatment	$150	$300
Epidural Anesthesia Injection (per Injection)	$100, 2 maximum	$200, 2 maximum
Eye Injury	$100 for removal of foreign object, $200 for surgical repair	$200 for removal of foreign object, $400 for surgical repair
Fractures	To $2,500 for Non-surgical; To $5,000 for Surgical repair; Chip fracture: 25% of non-surgical benefit; Multiple fractures: 100% of highest sustained fracture	To $5,625 for Non-surgical; To $11,250 for Surgical repair; Chip fracture: 50% of non-surgical benefit; Multiple fractures: 200% of highest sustained fracture
Initial Hospital Admission	$500	$1,000
Initial Intensive Care Unit (ICU) Hospital Admission	$1,000	$1,500
Hospital Confinement (per Day)	$200, 365 days maximum	$300, 365 days maximum
Intensive Care Unit (ICU) Confinement (per Day)	$400, 30 days maximum	$600, 30 days maximum
Lacerations	To $400	To $800
Lodging (per Day)	$100 per day up to 30 days if more than 100 miles from residence	$200 per day up to 30 days if more than 100 miles from residence
Medical Appliances	$100	$225
Organized Youth Sports Benefit	25% of the benefit amount	25% of the benefit amount
Paralysis	$10,000 quadriplegia; $5,000 paraplegia/hemiplegia	$20,000 quadriplegia; $10,000 paraplegia/hemiplegia
Physical Therapy (per Session)	$25, 6 sessions maximum	$37.50, 6 sessions maximum
Physician Visit	$50 Initial, $50 Follow-up	$75 Initial, $75 Follow-up
Prosthesis	$500 for one, $1,000 for two or more	$750 for one, $1,500 for two or more
Rehabilitation Facility Confinement (per Day)	$50, 30 days maximum	$100, 30 days maximum
Surgery	$100 for Exploratory; $300 for Knee Cartilage; $1,000 for Abdominal or Thoracic; $500 for Ruptured Disc; to $600 Tendon, Ligament, or Rotator cuff	$225 for Exploratory; $675 for Knee Cartilage; $2,250 for Abdominal or Thoracic; $1,125 for Ruptured Disc; to $1,350 Tendon, Ligament, or Rotator cuff
Transportation	$300, if more than 100 miles from residence	$600, if more than 100 miles from residence
X-Rays	$25	$75

Accidental Death Benefits	Plan A	Plan B
Employee AD&D	$25,000	$25,000
Spouse AD&D	$12,500	$25,000
Child AD&D	$5,000	$10,000
Common Carrier	100%	100%
Accidental Dismemberment Benefits	**% of Plan A AD Benefit**	**% of Plan B AD Benefit**
Single Loss	50%	50%
Multiple Loss (Catastrophic)	100%	100%
Thumb / Finger / Toe	1%	1%
2+ Thumb / Finger / Toe	3%	3%
Speech	100%	100%
Wellness (Health Screening) Benefit	**Plan A**	**Plan B**
Wellness (Health Screening)	$50	$50

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How to File a Wellness Supplemental Health Benefits Claim

Simple, easy and fast

It's easy to file for the Wellness Benefit[1] 24/7/365 via our mobile app, website or by phone.

24/7 Online

File securely at **reliancematrix.com/individuals/claims**.

Mobile

Our site is mobile-responsive: Just tap, or scan the code above.

By phone

Speak to an intake specialist weekdays 9AM–9PM Eastern. Toll-Free: 855-RSL-CLAIM (855-775-2524)

Email or fax

You can also email your scanned claim form to **ClaimsIntake@rsli.com** or fax to 267-256-4262.

The Wellness Benefit will pay you the amount shown on the Schedule of Benefits for one health screening test performed during a twelve month period for you and your dependents[2], if applicable, provided:

- You and your dependents were covered under the policy at the time the test was performed.
- Any preventative health screening test not already performed at any time during the same 12-month period.
- The coverage includes any preventative health screenings, including, but not limited to, tests, diagnostic procedures, routine examinations and immunizations.

1 Referred to as a Health Screening Benefit in NH and WA

2 Only one (1) Wellness Benefit will be paid in a twelve (12) month period per covered individual, subject to a maximum of four (4) per family. This benefit is paid in addition to any other payments you or your dependents, if applicable, may receive under the Policy.

Health screening tests covered under the policy

Testing
ALT/AST (liver function test)
Blood test for triglycerides
Bone marrow test
Breast cancer blood test – CA15-3
Covid-19 diagnostic test
Fasting blood glucose test
Genetic test
Ovarian cancer blood test – CA125
PAP test
PSA (prostate cancer blood test)
Serum cholesterol test (HDL and LDL)
Serum protein electrophoresis (blood test for myeloma)
Stress test (bicycle or treadmill)

Procedure
Acupuncture treatment
Biopsy for cancer
Breast ultrasound
Chest x-ray
Chiropractic visit
Colonoscopy
Dental exam
Echocardiogram
Electrocardiogram

Diagnostic
Annual physical
Bone density for triglycerides
Eye exam
Flexible sigmoidoscopy
Hearing exam
Hemoccult stool analysis
Hepatitis screening
HIV screening
Immunizations
Mammography
Mental health screening
Skin cancer screening
Ultrasound screening

This brochure is not a contract. The availability of the described feature may vary by state. It is not available in CT, ID, MI, MN, NM, NH, NY, ND and WY for Group Accident. It is not available in MI for Critical Illness. Critical Illness coverage is provided by policy series LRS-9537-0118, et al. Accident coverage is provided by policy series LRS-9547-0318, et al. Hospital Indemnity coverage is provided by policy series LRS-9572-0519, et al. It is not available for ID, KS and NM for group hospital indemnity.

For more information, visit reliancematrix.com.

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RS-2791 (07/23)

Plan Highlights - High Plan

Voluntary Group Hospital Indemnity Insurance

Geo Academies

COVERAGE

Voluntary group hospital indemnity insurance provides a range of fixed, lump-sum daily benefits to help cover costs associated with a hospital admission, including room and board costs. These benefits are paid directly to the insured following a hospitalization that meets the criteria for benefit payment.

ELIGIBILITY

As Defined by the Employer.

Employee must be under age 70 to enroll. This plan does not allow for Late Applicants.

Dependents: You must be insured for your Dependents to be covered. Dependents are:

- Your legal spouse. Spouse must be under age 70 at date of application.
- Your dependent children from birth to 26 years.
- A person may not have coverage as both an Employee and Dependent.

FEATURES

- Guaranteed issue; no medical questions
- No pre-existing conditions exclusions
- Mental & Nervous and Substance Abuse treated same as any other hospital admission
- Military Services Leave of Absence Continuation
- No deductibles
- Portability
- HIPAA privacy compliant

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employee Paid.

BENEFITS

Hospital Room & Board Benefits	
Room & Board Benefit per Day (180 Daily Benefits per Coverage Year)*	$100
Hospital Critical Care Unit Benefits	
Critical Care Unit Benefits per Day (30 Daily Benefits per Coverage Year)	$200
Hospital Admission Benefit	
One Daily Benefit per Coverage Year	$1,000
Hospital Critical Care Admission Benefit	
One Daily Benefit per Coverage Year	$1,000
Nursery Confinement Benefit	
Ten Daily Benefits per Coverage Year	$100
Wellness Care**	
One Daily Benefit per Coverage Year	$50
Non-Insurance Services	
On-Call Travel Assistance	Included

**In no event will the Daily Benefits exceed 180 daily benefits per Coverage Year.*
***Wellness Care means medical examinations and procedures that are preventive in nature and not for the treatment of Injury or Sickness.*

SEMI-MONTHLY PREMIUM

Coverage	Premium
Employee	$ 9.95
Employee & Spouse	$ 17.85
Employee & Child(ren)	$ 13.53
Employee & Family	$ 21.17

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Plan Highlights - Low Plan

Voluntary Group Hospital Indemnity Insurance

Geo Academies

COVERAGE

Voluntary group hospital indemnity insurance provides a range of fixed, lump-sum daily benefits to help cover costs associated with a hospital admission, including room and board costs. These benefits are paid directly to the insured following a hospitalization that meets the criteria for benefit payment.

ELIGIBILITY

As Defined by the Employer.

Employee must be under age 70 to enroll. This plan does not allow for Late Applicants.

Dependents: You must be insured for your Dependents to be covered. Dependents are:

- Your legal spouse. Spouse must be under age 70 at date of application.
- Your dependent children from birth to 26 years.
- A person may not have coverage as both an Employee and Dependent.

FEATURES

- Guaranteed issue; no medical questions
- No pre-existing conditions exclusions
- Mental & Nervous and Substance Abuse treated same as any other hospital admission
- Military Services Leave of Absence Continuation
- No deductibles
- Portability
- HIPAA privacy compliant

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employee Paid.

BENEFITS

Hospital Room & Board Benefits	
Room & Board Benefit per Day (180 Daily Benefits per Coverage Year)*	$50
Hospital Critical Care Unit Benefits	
Critical Care Unit Benefits per Day (30 Daily Benefits per Coverage Year)	$50
Hospital Admission Benefit	
One Daily Benefit per Coverage Year	$500
Hospital Critical Care Admission Benefit	
One Daily Benefit per Coverage Year	$500
Nursery Confinement Benefit	
Ten Daily Benefits per Coverage Year	$50
Wellness Care**	
One Daily Benefit per Coverage Year	$25
Non-Insurance Services	
On-Call Travel Assistance	Included

**In no event will the Daily Benefits exceed 180 daily benefits per Coverage Year.*
***Wellness Care means medical examinations and procedures that are preventive in nature and not for the treatment of Injury or Sickness.*

SEMI-MONTHLY PREMIUM

Coverage	Premium
Employee	$ 4.56
Employee & Spouse	$ 8.42
Employee & Child(ren)	$ 5.76
Employee & Family	$ 9.62

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GROUP WHOLE LIFE INSURANCE

The ABC's of **Living Care[1] benefits**

Long-term chronic illnesses can have a significant impact on an individual's quality of life, both physically and financially. These types of illnesses often require ongoing medical treatment and care, which can be costly and financially devastating for individuals and their families. Atlantic American's Whole Life plan allows you to access a portion of your life insurance benefits while living. We call this Living Care.

You may not have a long-term illness now, but let's consider how you may use a hybrid life plan.

Living Care[1] ABC's

Example Election: | **Whole LIfe** $70,000 ▶ | **Living Care** 4% up to 50 months ▶ | **Death Restoration**

A

What if you need care for a long-term illness?

You are able to use our Living Care benefit with a maximum **monthly benefit $2,800,** for up to **50 months.**

When you pass away, your beneficiary still receives a **Death Benefit of 25%,** or **$17,500.**

Use it all and get restored

B

What if you need care for a brief period of time?

You could have a serious illness that leaves you needing care for a brief period. **You use only $28,000** for your care, before passing away.

The remainder of your policy, **$42,000,** is paid to your beneficiary as a **death benefit.**

Use some and leave some

C

You could pass away, without ever needing care

The entire **$70,000** face amount of your policy will be paid as a **death benefit** to your beneficiaries.

Keep it all as a legacy

[1]The Living Care Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance. It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. Pre-existing condition limitation may apply. Living Benefits may not be available in all states or may be named differently. Please consult your policy for complete details. This hypothetical example does not guarantee or predict actual performance. This is an example for illustrative purposes only. Actual policy amounts and payments will depend on benefits purchased, death and living benefits.

GROUP WHOLE LIFE INSURANCE

Summary of Benefits

Atlantic American Employee Benefits' Group Whole Life insurance plan includes the benefits listed below. Each benefit is subject to conditions for payment as detailed in the certificate.

PLAN INFORMATION		
Available To	**ISSUE AGES**	**BENEFIT AMOUNT**
Employee	18-70	Up to $100,000 in $10,000 increments
Spouse Coverage*	18-65	Up to $20,000, in $10,000 increments - up to 100% of employee election. Based on spouse age.
Dependent Coverage*	15 days - age 25	$10,000 - up to 100% of employee election. Term rider continues to age 26 at which point they may choose to convert to an individual policy, up to 5x the Child's coverage amount, on a guarantee issue basis.

ADDITIONAL PLAN DETAILS	
Portability	Included

RIDERS	
Employee	Accelerated Death Benefit for Terminal Illness Rider - Insured can receive up to 50% of elected face amount during their life when there are diagnosed with a terminal illness that leaves them with a life expectancy of 12 months or less.
	Waiver of Premium Rider - Plan premiums are waived during disability period when insured has been disabled for 6 months. Included on issue ages 18-65; terminates at age 70.
	Accelerated Death Benefit for Chronic Illness Rider with Extension of Benefits Rider - Provides a 4% monthly benefit, up to 200% of certificate face amount.
	Restoration of Benefits Rider - Restores 25% of the death benefit for the beneficiary in the event the Acceleration for Chronic Illness Rider is exhausted.
Spouse	Accelerated Death Benefit for Terminal Illness Rider
	Accelerated Death Benefit for Chronic Illness Rider with Extension of Benefits Rider - 4% monthly benefit, up to 200% of certificate face amount.
	Restoration of Benefits Rider - Restores 25% of the death benefit for the beneficiary in the event the Acceleration for Chronic Illness Rider is exhausted.
Dependent(s)	Children's Term Rider

All benefit amounts are Guarantee Issue

* Employee coverage is required in order to elect spouse and/or dependent coverage.

Exclusions, Limitations and Other Plan Information

GROUP WHOLE LIFE

EXCLUSIONS – No Benefits are provided for the following, nor will We pay any expenses incurred as a result of any Loss which is caused by, or sustained while, or incurred for, directly or indirectly:1) suicide – If the Insured, whether sane or insane, dies by Suicide, within two (2) years* from the Effective Date, Our liability will be limited to an amount equal to the premiums paid for this Certificate.

* 1 year in CO, MO, ND.

OTHER LIMITATIONS AND EXCLUSIONS – The policy and riders have other elimination periods, exclusions and limitations that may affect coverage. Please refer to your certificate for full details.

DELAYED EFFECTIVE DATE PROVISION – Atlantic American Employee Benefits will postpone the Effective Date of an eligible Spouse/Dependent, other than a newborn child's coverage if, on that date, he or she is: 1) confined to a hospital or other health care facility; 2) home confined; or 3) unable to perform two or more daily living activities. In that case, we will postpone the Effective Date of his or her coverage until the day after the date: (a) of his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she is no longer requires assistance with two or more activities of daily living. If a Spouse/Dependent was covered under a prior plan at replacement, this language will not apply to the amount of coverage that was in force with the prior plan.

QUALIFYING CHRONIC ILLNESS – a Chronic Illness: 1) that was Diagnosed no more than twelve (12) months prior to the date We received a claim for benefits under this Rider; 2) that has continued while this Rider has been In Force for at least ninety (90) consecutive Days; 3) which was not caused by a mental or nervous disorder (except organically demonstrable disorders, such as Alzheimer's or senile dementia), alcoholism or drug addiction; and 4) which is expected to be Permanent.

PORTABILITY OPTION – If you, an employee, lose eligibility for this insurance, coverage can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue coverage.

COVERED CHILDREN AND GRANDCHILDREN – Children are covered if the child is a natural, step, or legally adopted child and dependent of the employee. A grandchild is covered if the child is a dependent of the employee and filed as such on their federal tax returns. Children/grandchildren must reside in the U.S. to receive coverage.

CONVERSION – Within the 31-day period after the expiration date of the term insurance on each Dependent Child, such term insurance may be converted to a new whole life policy without evidence of insurability up to 5x the term rider coverage amount.

EXPIRATION OF CHILDREN TERM INSURANCE – The term insurance on each Dependent Child will expire on the earlier of 1) the end of the month of the child's 26th birthday; or 2) the date the Certificate matures or becomes paid up for its full Face Amount.

GROUP WHOLE LIFE INSURANCE

$8,910

was the monthly median cost for a private room in a nursing home facility in 2021.

https://bit.ly/3Fflouk

chance that someone turning 65 will need long-term care services in their remaining years.

almost **70%**

https://bit.ly/3uTPdxs

Group Whole Life policy form series B 21803 GMP, Accelerated Death Benefit Rider for Terminal Illness form B 21803 R1 ACL, Accelerated Death Benefit Rider for Chronic Illness form B 21803 R12 CIACL, Restoration of Benefits Rider for Chronic Illness form B 21803 R13 ROBCI, Extension of Benefits Rider form B 21803 R14 EOBR, Children's Term Insurance Rider form B 21803 R8 CTR, Waiver of Premium for Disability Rider form B 21803 R9 WPD, and Accidental Death and Dismemberment Rider form B 21803 R10 ADD underwritten by Bankers Fidelity Life Insurance Company®. Limitations and exclusions apply; the terms and conditions in the actual policy and certificate provisions control. Refer to the specific policy and certificate for details. Application to determine eligibility may be required. The Policy, any optional Riders and the benefits therein are subject to availability and may vary by state. This is only a summary of products and services offered; actual offerings may vary by group size and other underwriting or legal considerations. This is a solicitation of insurance and an independent agent may call on you.

Group Customer Care
(866) 458-7502
groupcustomercare@atlam.com
aaemployeebenefits.com

ATLANTIC AMERICAN
Employee Benefits

Easy access to coverage

MyCoverage is an easy-to-use website that allows you to access coverage and benefit information 24/7, update your profile and more.
mycoverage.atlam.com

Retirement Planning

403B Retirement Savings Plan

What is a 403B plan? A 403B Plan is a tax-deferred retirement plan available to employees of public educational institutions and certain tax-exempt organizations. A 403B Plan allows you to make pre-tax contributions conveniently through payroll reduction to establish savings for retirement. To help you save for retirement, GEO offers a Retirement Savings Plan — your GEO 403B Plan, managed by Empower Investments. Please note, participation is available to all staff, however, not everyone will receive a match. GEO Academies, Corporate Office Staff- GEO contributes through the company matching contribution by matching 200% of up to 3% of your salary.

These contributions are 100% vested one year from your start date. You can contribute up to 50% of your pay through automatic payroll deductions, up to the IRS annual maximum ($22,500[1] for 2024). If you will be age 50 or older in 2024, you may contribute an extra $6,500. You can make pre-tax and/or Roth after-tax contributions. Please refer to the enclosed supplement for company contribution information.

Eligibility and Enrollment Access

All eligible new hires may enroll in the 403b plan immediately upon hire. **Please note, if you do not enroll in the plan yourself or decline the plan within the first 30 days of employment, you will be automatically enrolled in the plan at a 2% payroll deduction and your contributions will go into a pre- determined target date fund.**

All new employees will receive a mailing from Voya to your home address, with valuable information on the features of the plan and how to enroll in or decline the plan.

Enrollment into the plan is done through the Voya website. voyaretirementplans.com or you can call Voya customer service @ (800) 584-6001.

If you are an Indiana employee, you are encouraged to enroll in the plan even though you do not receive a company match. You receive matching funds from the company through your mandatory INPRS enrollment. See page 29 for more INPRS plan details.

If you waive this benefit now, you may choose to enroll in the 403B Plan at any other time throughout your employment.

Eligibility Requirements

Employees, (excluding Temporary, Seasonal or Per Diem) that average a minimum of 20 hours per week on a regular basis, become eligible for the 403b Plan effective upon the first date of hire following completion of enrollment documentation.

How the Plan Works

You may make pre-taxed or after-tax contributions to the 403B Plan through regular payroll deductions.

Employer Match

GEO will add an additional 200% of what you contribute to the plan, up to 3% of your salary.
Note: Indiana employees do not receive this match. Your co. match will come through your INPRS plan.

Retirement Planning

Contributions
You can contribute a percentage of your eligible pay on a pre-income tax basis up to $22,500 per year for 2024.

Catch Up Contributions
Anyone age 50 or older in 2024 may contribute an additional $7,500.

Changing Contribution Level
You may change your contribution amount through your online account. You may terminate a salary reduction agreement at any time.

Vesting
Your contributions are always 100% vested. GEO matching contribution are 100% vested after one year.

Loans
Although your plan is intended primarily as a means of saving for retirement, there may be times when you'll feel the need to borrow against your account balance. You may apply for a loan against your qualified account balance online. You will pay back the loan via payroll deduction. The plan allows for 2 active loans at any given time.

Plan Representatives

Brent Gramman
Financial Advisor
(317)-506-6676
brent.gramman@ampf.com

Jacob Conn
Client Services
(317)-818-9365
jacob.1.conn@ampf.com

Indiana Public Retirement System, (INPRS) PERF and TRF

PERF and TRF

If you're new to PERF and have been enrolled in the PERF Hybrid or My Choice plan by your employer, choose from "I'm a Public Employees' Retirement Fund (PERF) Member" under Plan-specific New Member Information below to learn more about your plan.
If you're a new teacher or public employee with a choice between the Hybrid or My Choice plans, you have 60 days from your date of hire to choose your retirement options. If you do not choose within 60 days, you will be automatically enrolled in the designated default plan. Your choice, or default, is irrevocable so please make an informed decision.
INPRS Member Advocates and Retirement & Financial Education consultants can help you learn about the differences. You may also want to consult your financial advisor.

You can find out more info by going to www.in.gov and searching INPRS or contact INPRS by phone at (844) GO-INPRS or by email at questions@inprs.in.gov.

Additional Benefit Offerings

The Association of American Educators (AAE)

The AAE is a professional membership organization that offers a variety of resources through various partnerships. GEO provides this benefit to specific full-time educators and admin at our schools. **Member benefits include:** $2,000,000 professional liability insurance policy • Legal assistance for employment rights issues • Professional development resources • Scholarships and classroom grants • Informative publications and newsletters • Discounts on shopping, restaurants, and entertainment • A non-partisan voice on education policy • Access to supplementary insurance plans • Membership in a national association that promotes professionalism, collaboration, and excellence.

GEO encourages employees to take advantage of undergraduate and graduate degree programs to further develop their current job skills and prepare for future positions within the company.

Employee Time Off

GEO provides paid time away from work through holidays and paid time away. Please refer to the current handbook for specifics.

Employee Assistance Program (EAP)

GEO provides an extensive EAP through KEPRO. The EAP provides Emotional Wellness, Caregiving, Legal, Financial, and Convenience services with up to 5 face-to-face visits per employee per year.

GET TO KNOW YOUR

Employee Assistance Program

Administered by Acentra HEALTH

Your Employee Assistance Program (EAP) is a complimentary service available to you through your employer. The EAP provides counseling sessions at no cost to you, as well as offering a wide variety of services to enhance overall wellbeing and support healthy work/life balance. Services and commonly addresses issues are described below. The program is completely confidential and available to you, your household family members, and dependents.

EAP SERVICES & RESOURCES

KANSAS CITY LIFE GROUP BENEFITS

IMMEDIATE 24/7 SUPPORT AND GUIDANCE

Master's level counselors and work/life specialists are standing by twenty-four hours a day, seven days a week, 365 days a year to answer any questions about the program, provide in-the-moment guidance, and connect you to any of the resources described below.

COUNSELING & SUPPORT

Whether you are dealing with stress, anxiety, depression, relationship issues, substance abuse issues, work issues, or other challenges, we can help. Let us connect you with a highly qualified counselor for in-person, phone, or video counseling sessions. You, your household family members, and dependents are eligible for free confidential counseling sessions.

ONLINE TOOLS & RESOURCES

The EAP website listed below is your one-stop resource for tools and information designed to address life's pressing concerns. You will find webinars, self-assessments, soft skills trainings, podcasts, articles, and more. Additionally, you can access calculators, childcare and eldercare resources, download legal and financial forms, and more.

MANAGEMENT & ORGANIZATIONAL SERVICES

Unlimited telephonic consultations are available to leadership to provide solutions to complex individual and team issues, including ways to reduce conflict and address performance and behavioral issues. The EAP also provides immediate guidance and support following a traumatic or critical incident that impacts the workplace, including coordination of critical incident debriefings.

LEGAL CONSULTATION

Legal concerns can be stressful, costly and often result in lost work time. Reach out to the EAP for a referral for a free 30-minute consultation with a lawyer for any issue (excluding work related issues). After the 30-minutes, you will receive a 25% discount for additional time and services. General legal information and forms, including a simple will form, can be found on the website.

FINANCIAL CONSULTATON

Sometimes we don't know where to start when we are having financial issues or need help budgeting, saving, or have other financial questions. Contact the EAP for a free 30-minute phone consultation with a financial expert. Additional information on budgeting, debt management, and getting ready for retirement can be found on the website.

WORK/LIFE SUPPORT & REFERRAL SERVICES

Let us do the leg work when it comes to researching fitness centers, colleges, adoption services, relocation services, volunteer opportunities, pet care, entertainment, doctors, home repair services, and so much more. Your time is too valuable; our research team is standing by to do the work for you.

CAREGIVER SUPPORT SERVICES

Are you looking for childcare, summer camps, afterschool activities, or back-up care? Need help finding referrals for assisted living facilities or in-home care for an older parent? We can help. Reach out to speak to one of our Child or Elder Specialists, available 24/7. In addition to referrals, they can offer expert advice and guidance tailored to your area of need.

CALL TOLL-FREE, 24/7:
1.877.239.8783

WEBSITE:
www.EAPHelplink.com
Code: KCLEAP5

SCAN ME

Scan this QR code using your phone camera to go directly to the EAP website

Value Added Services from Generali Global Assistance

The benefits of doing business with Kansas City Life Insurance Company go beyond our exceptional Group coverage. By selecting Kansas City Life to provide your coverage, employees will have access to outstanding services from our partner, Generali Global Assistance (GGA). Value Added Services – just one of many benefits of choosing Kansas City Life.

Beneficiary Companion

Travel Assistance

Identity Theft

GENERALI
GLOBAL ASSISTANCE

You can count on Generali Global Assistance 24/7/365. Take a look at the benefits.

Available 24 hours a day
866-409-4690
+1-240-330-1462 (Collect outside the U.S.)
ops@us.generaliglobalassistance.com

Beneficiary Companion

A service with survivors in mind

At a time of loss, the last thing survivors want to do is make phone calls and handle paperwork. With Kansas City Life's Group Benefit's Beneficiary Companion, they don't have to. Generali Global Assistance will take care of the administrative details involved in closing a loved one's affairs, relieving the stress of paperwork and allowing beneficiaries to focus on the healing process.

Guidance

Kansas City Life Group Benefit's Beneficiary Companion service offers the following types of support:

- Guidance on how to obtain death certificate copies (necessary for performing final notifications)
- 24/7 live support and counsel from a dedicated Beneficiary Assistance Coordinator
- The Beneficiary Companion Guidebook that serves as a handy reference tool for beneficiaries navigating the aftermath of a loved one's death

Assistance

Dedicated Beneficiary Assistance Coordinators manage the assistance process which includes notification to the following:

- Social Security Administration
- Credit reporting agencies
- Credit card companies
- Banks and other financial institutions
- Third-party vendors
- Government agencies

Social media shut down

In an increasingly digital world, it's more common than ever for loved ones to have an active social media presence. However, it can be an emotionally painful and time-consuming process to bring closure to those accounts. Our coordinators can work with the beneficiary to:

- Discontinue access to loved one's social media accounts
- Assist with memorialization of eligible accounts to preserve a loved one's digital profile

Identity protection and fraud resolution

Every year the identities of nearly 2.5 million deceased Americans are stolen to fraudulently open accounts, obtain loans, tax refunds, and other services, according to the IRS[1]. Studies have shown that a deceased person's identity is an attractive target for criminals, especially given the relative ease of obtaining their personally identifiable information. GGA's Identity Protection services give beneficiaries additional peace of mind by providing guidance on how to protect their loved one's identity and resolution assistance in the event of identity theft. Services include:

- Review of credit report with the beneficiary
- Suppression of the deceased person's credit report or a freeze/closure of the account with credit bureaus
- Full-service resolution assistance should there be an incident of identity theft, including affidavit assistance, credit bureaus and fraud department notification, help filing police report, creditor follow-up, and other services

[1]https://hrhcpa.com/ghosting-exploits-the-stolen-identities-of-the-dead

Travel Assistance

Safe travels with travel assistance services

With Generali Global Assistance (GGA), one quick phone call can take the hassle out of a traveling emergency. When you travel 100 miles or more away from home on trips of 90 days or less, you have access to travel medical and personal assistance services.

With a local presence in 200 countries and territories worldwide and 24/7/365 assistance centers staffed with multilingual assistance coordinators and case managers as well as medical staff, GGA is here to help you obtain the care and attention you need in case of an emergency while traveling.

In the event of a life-threatening emergency, call the local emergency authorities first to receive immediate assistance, and then contact GGA.

Available travel assistance services

Emergency medical payment

GGA will advance on-site emergency inpatient medical payments to you, up to $10,000 USD upon receipt of satisfactory guarantee of reimbursement from you. The cost of medical services is your responsibility.

Medical search and referral

GGA will assist you in finding physicians, dentists and medical facilities.

Replacement of medication and eyeglasses

GGA will arrange to fill a prescription that has been lost, forgotten or requires a refill, subject to local law, whenever possible. GGA will also arrange for shipment of replacement eyeglasses. Costs for shipping of medication or eyeglasses, or a prescription refill, etc. are your responsibility.

Medical monitoring

During the course of a medical emergency resulting from an accident or sickness, professional case managers, including physicians and nurses, GGA will monitor your case to determine whether the care is appropriate.

Visit by family member/friend

If you are traveling alone and must be or are likely to be hospitalized for seven or more days or are in life-threatening condition, GGA will arrange and coordinate payment for the round-trip transportation for one family member or friend, designated by you from his or her home to the place where you are hospitalized. Transportation costs are the responsibility of you, your family member or friend.

Dependent children assistance

If any dependent children under the age of 19 traveling with you are left unattended because you are hospitalized, GGA will coordinate and arrange payment for their economy class transportation home. Should transportation with an attendant be necessary, GGA will arrange for a qualified escort to accompany the child(ren). Transportation cost is your responsibility.

Traveling companion assistance

If a travel companion loses previously made travel arrangements due to your medical emergency, GGA will arrange for your traveling companion's return home. Transportation costs are the responsibility of you or your traveling companion.

Emergency evacuation/medically necessary repatriation

In the event of a medical emergency, when a physician designated by GGA determines that it is medically necessary for you to be transported under medical supervision to the nearest hospital or treatment facility or be returned to your place of residence for treatment, GGA will coordinate and arrange payment for the transport under proper medical supervision.

Repatriation of mortal remains

In the event of your death while traveling, GGA will coordinate and arrange payment for all necessary government authorizations, including a container appropriate for transportation and for the return of the remains to place of residence for burial.

Trip interruption

If you or an immediate family member is critically injured, sick or dies while traveling, GGA shall arrange for you or your immediate family member's return to the preferred place of hospitalization or burial via the most direct route on economy class airfare. Transportation cost is your responsibility.

Additional travel assistance services

Pre-trip information – Know what you need from currency exchange to consulate referrals before heading out.

Language translation – Get assistance from an interpreter on the phone or on site.

Lost/stolen items – Retrieve lost or stolen luggage, ticket documentation or personal items.

Emergency cash – Emergency advances of up to $500 USD are available in a time of need. (Transfer/deliver fees are your responsibility.)

Emergency travel – Airline, hotel and/or car rental reservations are made during an emergency.

Legal assistance – Legal assistance and bail are available if you're arrested. (Service costs are your responsibilities.)

Emergency messaging – Urgent messages will be sent to your family, friends or associates during an emergency.

Vehicle return – If you're unable, GGA will arrange payment and return of your rental during an emergency. (Service costs are your responsibility.)

Pet return – Hospitalized? GGA will arrange to return your pets home. (Service costs are your responsibility.)

Identity Theft

Protect yourself against identity theft

While the means to detect and prevent identity theft continue to evolve, the crime continues to impact millions of Americans every single year. As criminals continue to search for new ways to commit identity theft, with social networks and healthcare records becoming growing areas to exploit, identity theft is an ever-increasing problem.

Comprehensive protection

Generali Global Assistance (GGA) basic identity theft protection program provides consumers with the information to protect themselves and guidance to help them resolve identity theft. This cost-effective solution offers:

Prevention

- Identity theft prevention kit
- Expertise available 24/7 (support available immediately upon enrollment)

Detection

- Three bureau fraud alert placement assistance

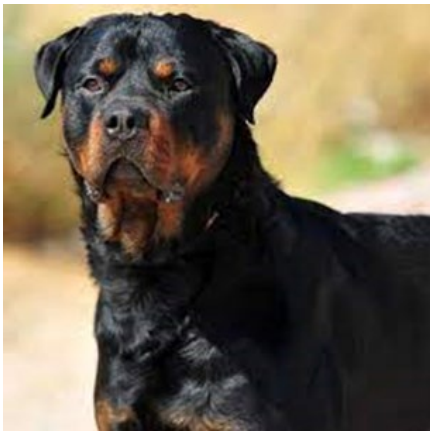
Resolution

- Credit information review
- ID theft affidavit assistance
- Wallet protection
- Translation service
- Emergency cash advance

Additional Benefit Offerings

Pet Insurance

Nation Wide Pet Insurance- My Pet Protection Plan



My Pet Protection plans offer comprehensive coverage for dogs, cats, avian and exotic pets.

Coverage includes medical, accidents, injuries illnesses, hereditary, surgeries, and more. Use any vet, anywhere: no networks, no pre-approvals. **Additional benefits for above and beyond medical care.**

Dogs, cats, birds, reptiles and other exotic pets (e.g. rabbits, ferrets, miniature pigs, etc.) are eligible for enrolment.

Cost and Discounts

- ✓ Exclusive to employees, not available to public.
- ✓ Preferred pricing built into plan options.
- ✓ Multi-pet discounts available

Benefits

- ✓ Cash back on eligible vet bills after $250 annual deductible is met.
- ✓ Levels of reimbursement: 50% and 70%
- ✓ $7,500 benefit which renews each year in full.

What's not covered? Pre-existing conditions, wellness, boarding, and grooming.

Some policy exclusions may apply. Discount on base plans only and may vary by state.

Vethelpline is available to all members. Receive 24/7 veterinary advice. Unlimited 24/7 access to call, email, or chat online. Nationwide PetRxExpress is optional to all Nationwide pet insurance members with active plans at no additional cost to sign up or utilize and allows you to obtain pet medications for less at Walmart. Policies are renewed annually.

Pet insurance

from Nationwide®

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

- **Get cash back on eligible vet bills:** Choose 50% or 70% reimbursement[1]
- **Easy to use:** Low $250 annual deductible and $7,500 in annual benefits
- **Just for employees:** Preferred pricing offered only through your company
- **Use any vet, anywhere:** No networks, no pre-approvals

Did you know? Nationwide is the first provider with coverage plans 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/geofoundation / 877-738-7874

[1] Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states.

Nationwide®

Nationwide®

My Pet Protection®

PLAN SUMMARY

Nationwide[1] pet insurance helps you cover veterinary expenses so you can provide your pets with the best care possible—without worrying about the cost.

My Pet Protection coverage highlights

My Pet Protection is available in two reimbursement options (50% and 70%) so you can find coverage that fits your budget. All plans have a $250 annual deductible and $7,500 annual benefit.

Coverage include[1]:

- Accidents
- Illnesses
- Hereditary and congenital conditions
- Cancer
- Behavioral treatments
- Rx therapeutic diets and supplements
- And more

My Pet Protection includes these additional benefits for cats and dogs:

- Lost pet advertising and reward expense
- Emergency boarding
- Loss due to theft
- Mortality benefit

What makes My Pet Protection different?

My Pet Protection is available only through your employer, which includes preferred pricing and is guaranteed issuance. It also includes additional benefits like lost pet advertising, emergency boarding and more.

It's no surprise that My Pet Protection is the most paw-pular coverage plan from America's #1 pet insurer.

Did you know? Nationwide is the first provider with coverage plans for birds and exotic pets.

Nationwide offers more than great coverage

vethelpline®

- 24/7 access to veterinary experts
- Available via phone, chat and email
- Unlimited help for everything from general pet questions to identifying urgent care needs

Nationwide PetRx*Express*℠

- Save time and money by filling pet prescriptions at participating in-store retail pharmacies across the U.S.
- Rx claims submitted directly to Nationwide
- More than 4,700 pharmacy locations

https://benefits.petinsurance.com/geofoundation / 877-738-7874

[1]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.

Nationwide®

Nationwide®
PetRx*Express*℠

Save time and money when filling pet prescriptions at a Walmart or Sam's Club pharmacy with Nationwide® **PetRx***Express*℠.

For no extra cost, our pet insurance members get discounts on Walmart's already low prices while enjoying the effortless convenience of automatic claim submission.

How it works

Using Nationwide® **PetRx***Express*℠ is easy and convenient for Nationwide pet insurance members.

1. Download a digital pet insurance card at **my.petinsurance.com**.
2. Take a prescription to any in-store Walmart or Sam's Club pharmacy, or have the veterinarian call it in.
3. Show the pet insurance card at the checkout and pay for the prescription.

That's it! The pharmacy will automatically submit a claim to Nationwide for processing, and you will be reimbursed for eligible expenses.*

*Reimbursement or co-insurance is based on coverage detailed in policy. See Nationwide **PetRx***Express*℠ Terms of Service. Certain coverages may be excluded due to pre-existing conditions. See policy documents for a complete list of exclusions.

Get prescription pet meds for less

- Optional program available to all active Nationwide pet insurance members
- Receive discounted pricing on medications not covered by pet insurance
- No cost to use

https://benefits.petinsurance.com/geofoundation / 877-738-7874

Nationwide®

How to apply for a pet insurance policy

Nationwide® pet insurance provides coverage for veterinary expenses related to accidents and illnesses. Policies are available for dogs, cats, birds, reptiles and other exotic pets.

Signing up for pet insurance is easy

https://benefits.petinsurance.com/geofoundation / 877-738-7874

During enrollment, you may be asked for the following information:

- Name
- Address
- Home or primary telephone number
- E-mail address
- Name and age of your pet
- Pet's species (canine, feline, etc.)
- Payment information/plan*

*Applications approved between the 1st and the 15th of the month become effective on the 1st of the following month. Applications approved from the 16th through the end of the month become effective on the 1st of not the following month, but the month thereafter.

Example: May 1 approval = June 1 effective date
May 16 approval = July 1 effective date

Nationwide®

BEHIND THIS PAGE, YOU WILL FIND…

Frequently Asked Questions and Important Annual Federal Notices

FREQUENTLY ASKED QUESTIONS –

I need my dental and vision cards, where can I get a copy of them?

Members can print ID cards, locate providers, view claims, and more on www.UnifiedGrp.com**,** www.cignadental.com, https://www.kclgroupbenefits.com/Vision/

I have a qualifying event and need to add/drop someone to/from my insurance, what do I need to do?

The employee has 30 days to notify the HR Benefits Administrator of the event. For example, an employee married on November 12, 2023, must notify GEO by December 12, 2023, if they want to add their new spouse to the GEO line of coverage. Any notification beyond thirty days will not be allowed and the employee will have to wait until the next Open Enrollment period to make changes.

One of my dependents passed away, what do I need to do?

To submit a Life Insurance claim, please contact the HR Benefits Administrator.

If there is no beneficiary listed in either scenario, a preferential beneficiary form may be completed. This form may be used if the beneficiary on file is deceased, and proof of death has been received by GEO.

I need to make a claim for LTD/STD, where can I find the form?

Please contact Donna Trisler @ dtrisler@geoacademies.org for an LTD/STD claim form to complete.

I need to make a claim for FMLA, where can I find the form?

Please contact Donna Trisler @ dtrisler@geoacademies.org for an FMLA form to complete.

What is the process of filing for a LOA?

Benefits while on LOA:

→ **Leaves of Absence and No-Pay Status**
If you are on a leave of absence or no-pay status, you must contact Human Resources to ask what impact your absence may have on your participation in the Health Plan.

→ **Leave of Absence with Pay** If you are granted a leave of absence with pay, your Health Plan coverage will continue, provided your usual payroll deductions continue.

→ **Leave of Absence Without Pay and No-Pay Status** If you are granted a leave of absence without pay or no-pay status, you may continue your Health Plan coverage during your leave, provided you pay the employee cost of continuing this coverage. If you choose to continue coverage, you must contact Human Resources before you begin your leave to make the necessary billing arrangements. This coverage will be automatically canceled if you fail to make the required payments. If you do not wish to continue your coverage during your unpaid leave of absence, you may discontinue your membership by notifying in writing, Human Resources.

Know Your Benefits

Frequently Asked Questions About Using HSAs

How do I manage my HSA?

Your health savings account (HSA) is your account; the HSA dollars are your dollars. Since you are the account holder or HSA owner, you manage your HSA account. You may choose when to use your HSA dollars or when not to use your HSA dollars. HSA dollars can pay for qualified medical expenses on a tax-free basis. Most commonly, HSA owners use HSA dollars to pay the out-of-pocket expenses associated with their high deductible health plan (HDHP), such as the deductible or any coinsurance.

What expenses are eligible for tax-free reimbursement from my HSA?

Your HSA dollars may be used on a tax-free basis for qualified medical expenses incurred by you, your spouse or your dependent children.

Qualified medical expenses include payments for medical services rendered by physicians, surgeons, dentists and other medical practitioners. They also include the costs of equipment, supplies and diagnostic devices needed for these purposes. Medical care expenses must be primarily to alleviate or prevent a physical or mental disability or illness. They don't include expenses that are merely beneficial to general health, such as vitamins or a vacation.

In addition, the following insurance premiums may be reimbursed from an HSA on a tax-free basis:

- Health care continuation premiums (for example, COBRA premiums)
- Health insurance premiums while receiving unemployment benefits
- Qualified long-term care premiums
- Any health insurance premiums paid, other than for a Medicare supplemental policy, by individuals ages 65 and over

Are dental and vision care qualified medical expenses under an HSA?

Yes, as long as they would qualify for the medical and dental expenses deduction under federal tax law. This deduction is explained in IRS Publication 502, “Medical and Dental Expenses.” For example, cosmetic procedures, like cosmetic dentistry, are not considered qualified medical expenses.

What medical expenses are NOT eligible for tax-free reimbursement from my HSA?

The following medical expenses may not be reimbursed from an HSA on a tax-free basis:

- Premiums for Medicare supplemental policies
- Expenses covered by another insurance plan
- Expenses incurred prior to the date the HSA was established

Can I use my HSA dollars for other expenses?

You are permitted to take a distribution from your HSA at any time and for any reason; however, only those amounts used exclusively to pay for qualified medical expenses are tax-free. Any amounts you withdraw from your HSA that are not used to pay for qualified medical expenses are taxable income to you. These amounts are also subject to a 20% tax penalty unless you are age 65 or older, disabled or deceased.

Gregory & Appel INSURANCE

Know Your Benefits

What if I want to use my HSA to pay for long-term care insurance?

This is allowed. HSA distributions used to pay for long-term care insurance premiums qualify as tax-free distributions. However, there is an annual limit to the amount you may contribute toward this expense, which is adjusted by the IRS every year.

When can I start using my HSA dollars?

You can use your HSA dollars immediately following your HSA account activation and once contributions have been made.

When, and how often, can I contribute to my HSA account?

You, your employer or others can contribute to your HSA account through payroll deductions or as a lump sum deposit. You can contribute as often as you like, provided the total contributions to your HSA for 2023 do not exceed $3,850 ($4,150 for 2024) if you have single HDHP coverage or $7,750 ($8,300 for 2024) if you have family HDHP coverage. Individuals who are ages 55 or older are eligible to make catch-up contributions up to $1,000.

How can I pay my physician or network facility at time of service with my HSA dollars?

You may request that the network provider submit your claim to your HDHP. You should make sure that your provider has your most up-to-date insurance information. Once the medical claim has been processed, if applicable, out-of-pocket expenses will be billed. At this time, you may choose to use your HSA debit card or HSA check (if available) to pay for any out-of-pocket expenses, or you may choose to pay with your own money and receive reimbursement at a later date. You should always ask that your medical claim be submitted to the HDHP before you seek reimbursement from your HSA. This will ensure that provider discounts are applied. Also, remember to keep all medical receipts and any explanation of benefits.

What if I have HSA dollars left in my account at year-end?

The money is yours to keep. It will continue to earn interest and will be available for you and your health care costs next year. Any dollars left in your HSA account at the end of the year will automatically roll over into the next year.

What happens to my HSA dollars if I leave my employer?

The funds are yours to keep. You may elect one of the following tax-free options:

- Leave your funds in the current HSA account.
- Request that your current HSA custodian directly transfer your funds to an HSA with your new employer.
- Receive a distribution of your HSA funds and roll over the funds to another HSA within 60 days.

What if I want to close my account?

In general, unless you transfer or roll over your HSA funds to another HSA account, your HSA funds will be subject to taxes if withdrawn for reasons other than a qualified medical expense.

Can my HSA dollars be used for retirement health care costs?

Yes, but only withdrawals for qualified medical expenses will be tax-free.

Can I use the money in my HSA to pay for my dependents' medical expenses tax-free?

You can use your HSA money to pay for the qualified medical expenses of yourself, your spouse or your dependent children on a tax-free basis. You can pay for qualified medical expenses of your spouse and dependent children even if they are not covered by your HDHP.

Can couples establish a joint account and both make contributions to the account, including catch-up contributions?

Joint HSA accounts are not permitted. Each spouse should consider establishing an account in his or her own name. This allows you to both make catch-up contributions when you are 55 or older.

Know Your Benefits

What if my spouse or family member wants to make contributions to my HSA?

Family members may make contributions on behalf of other family members. However, the total contribution made by you, your family member and your employer cannot exceed the annual contribution limit (with only a single exception for the additional catch-up contribution if the account holder is at least 55 years old).

My employer offers an FSA—can I have an FSA and still contribute to an HSA?

In most cases, you cannot have coverage under a health FSA and make contributions to an HSA. However, if your employer offers a limited-purpose health FSA (limited to dental, vision or preventive care) or a post-deductible health FSA (pays for medical expenses after the HDHP annual deductible is met), then you may still be eligible for an HSA.

What if I change my health coverage to a plan that doesn't allow an HSA?

If you no longer have coverage under an HDHP, you will have to stop making contributions to your HSA for that period of coverage. However, you will still be able to use your HSA funds on a tax-free basis to pay for qualified medical expenses.

Can I shift my IRA funds to my HSA?

Owners of individual retirement accounts who are enrolled in an HDHP plan can shift IRA funds to an HSA without facing a tax penalty. The IRS generally allows a one-time transfer that does not exceed your maximum HSA contribution limit.

Can I borrow against the money in my HSA?

No. You may not borrow against it or pledge the funds in it. For more information on prohibited activities, see Section 4975 of the Internal Revenue Code.

Can the funds in an HSA be invested?

Yes, you can invest the funds in your HSA. The same types of investments permitted for IRAs are allowed for HSAs, including stocks, bonds, mutual funds and certificates of deposit.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

General Notice of COBRA Rights

(For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;

Death of the employee;

- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

Amaiyah Cross
3145 North Meridian Street
Indianapolis, IN 46208

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act,

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

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

Plan contact information

2024 - 2025 Plan Year
Amaiyah Cross
3145 North Meridian Street
Indianapolis, IN 46208

General FMLA Notice

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

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

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical and surgical coverage. The MHPAEA was enacted on Oct. 3, 2008, to strengthen federal mental health parity requirements for health coverage. The MHPAEA supplemented the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. The MHPAEA also extended the parity requirements to substance use disorder benefits and added a Quantitative Treatment Limitation and Non-quantitative Treatment Limitation Analysis with the Consolidated Appropriations Act of 2021. The MHPAEA became effective for plan years beginning after Oct. 3, 2009. Under the MHPAEA, the financial requirements and treatment limits that group health plans and health insurance issuers apply to MH/SUD benefits generally cannot be more restrictive than those applicable to medical and surgical benefits.For information regarding the criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at 317-713-4226.

Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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%[2] 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.[3]

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

[2] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[3] 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.

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.

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 by your employer, please check your summary plan description or contact:

Amaiyah Cross
3145 North Meridian Street
Indianapolis, IN 46208

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.

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 GEO Foundation	4. Employer Identification Number (EIN) 95-4406881	
5. Employer address 3145 North Meridian Street	6. Employer phone number 317-536-1027	
7. City Indianapolis	8. State IN	9. ZIP code 46208
10. Who can we contact about employee health coverage at this job? Amaiyah Cross		
11. Phone number 317-713-4226	12. Email address across@geoacademies.org	

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

- As your employer, we offer a health plan to:

  ☑ Some employees. Eligible employees are: benefit eligible employees working 30-40 hours per week.

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are: Legal spouse without coverage available to them through their employer. Dependent child(ren) up to age 26.

☑ 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.

Note: 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.

Medicare Part D Non-Creditable Coverage Notice

Important Notice from GEO Foundation About Your Prescription Drug Coverage and Medicare
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with GEO Foundation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. GEO Foundation has determined that the prescription drug coverage offered by the GEO Foundation Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the GEO Foundation Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from the GEO Foundation Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join a Medicare Drug Plan?

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

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

Since the coverage under the GEO Foundation Plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, your current GEO Foundation coverage will be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current GEO Foundation coverage, be aware that you and your dependents will be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the person listed below for further information Amaiyah Cross at 317-713-4226. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through GEO Foundation changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

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

Date: 7/1/2024

Name of Entity/Sender: GEO Foundation

Contact--Position/Office: Amaiyah Cross, Benefits Administrator

Address: 3145 North Meridian Street Indianapolis, IN 46208

Phone Number: 317-713-4226

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $1650 deductible (in-network) and 20% coinsurance (in-network) and $3000 deductible (out-of-network) and 40% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at 317-713-4226.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 317-713-4226 for more information.

Newborns' and Mothers' Health Protection Act Notice

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

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

https://www.in.gov/healthcarereform/no-surprises-act/

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

https://www.in.gov/healthcarereform/no-surprises-act/

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

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

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

If you think you've been wrongly billed, contact the No Surprises Help Desk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

Notice of Patient Protections

The GEO Foundation Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact:

Amaiyah Cross

3145 North Meridian Street

Indianapolis, IN 46208

For children, you may designate a pediatrician as the primary care provider.

Notice of Privacy Practices

GEO Foundation
3145 North Meridian Street
Indianapolis, IN 46208

Privacy Official:
Amaiyah Cross
3145 North Meridian Street
Indianapolis, IN 46208

Effective Date: 09/01/2024

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

Get a list of those with whom we've shared information

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:
  Amaiyah Cross
  3145 North Meridian Street
  Indianapolis, IN 46208
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

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

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

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

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

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

Other Information

We will never share any substance abuse treatment records without your written permission.

Notice of Special Enrollment Rights

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

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

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact:

Amaiyah Cross

3145 North Meridian Street

Indianapolis, IN 46208

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
    - Initial employment;
    - Reemployment;
    - Retention in employment;
    - Promotion; or
    - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address:
http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

FREQUENTLY ASKED QUESTIONS –

I need my dental and vision cards, where can I get a copy of them?

Members can print ID cards, locate providers, view claims, and more on www.UnifiedGrp.com, www.cignadental.com, https://www.kclgroupbenefits.com/Vision/

I have a qualifying event and need to add/drop someone to/from my insurance, what do I need to do?

The employee has 30 days to notify the HR Benefits Administrator of the event. For example, an employee married on November 12, 2024, must notify GEO by December 12, 2024, if they want to add their new spouse to the GEO line of coverage. Any notification beyond thirty days will not be allowed and the employee will have to wait until the next Open Enrollment period to make changes.

One of my dependents passed away, what do I need to do?

To submit a Life Insurance claim, please contact the HR Benefits Administrator.

If there is no beneficiary listed in either scenario, a preferential beneficiary form may be completed. This form may be used if the beneficiary on file is deceased, and proof of death has been received by GEO.

I need to make a claim for LTD/STD, where can I find the form?

Please contact Amaiyah Cross @ across@geoacademies.org for an LTD/STD claim form to complete.

I need to make a claim for FMLA, where can I find the form?

Please contact Amaiyah Cross @ across@geoacademies.org for an FMLA form to complete.

What is the process of filing for a LOA?

Benefits while on LOA:

→ **Leaves of Absence and No-Pay Status**
If you are on a leave of absence or no-pay status, you must contact Human Resources to ask what impact your absence may have on your participation in the Health Plan.

→ **Leave of Absence with Pay** If you are granted a leave of absence with pay, your Health Plan coverage will continue, provided your usual payroll deductions continue.

→ **Leave of Absence Without Pay and No-Pay Status** If you are granted a leave of absence without pay or no-pay status, you may continue your Health Plan coverage during your leave, provided you pay the employee cost of continuing this coverage. If you choose to continue coverage, you must contact Human Resources before you begin your leave to make the necessary billing arrangements. This coverage will be automatically canceled if you fail to make the required payments. If you do not wish to continue your coverage during your unpaid leave of absence, you may discontinue your membership by notifying in writing, Human Resources.

Glossary

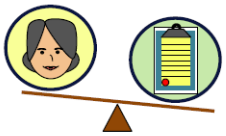
This glossary has many commonly used terms but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

- **Bold blue** text indicates a term defined in this Glossary.
- See the last page of this glossary for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real-life situation.

Allowed Amount:
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

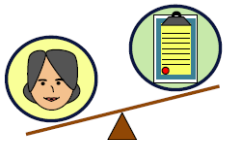
Appeal:
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing:
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Co-insurance:

Jane pays **20%** Her plan pays **80%**
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy:
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment:
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible:

Jane pays **100%** Her plan pays **0%**
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME):
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

Emergency Medical Condition:
An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation:
Ambulance services for an emergency medical condition.

Emergency Room Care:
Emergency services you get in an emergency room.

Emergency Services:
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services:
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance:
A complaint that you communicate to your health insurer or plan.

Habilitation Services:
Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance:
A contract that requires your health insurer to pay some or all your health care costs in exchange for a premium.

Home Health Care:
Health care services a person receives at home.

Hospice Services:
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization:
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care:
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance:
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment:
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary:
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

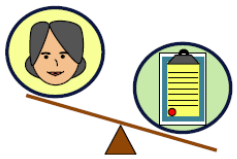
Network:
The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider:
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance:
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment:
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit:
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all your co-payments, deductibles, co-insurance payments, out-of-network payments, or other expenses toward this limit.



Physician Services:
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan:
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization:
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider:
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium:
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Prescription Drug Coverage:
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs:
Drugs and medications that by law require a prescription.

Primary Care Physician:
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

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

Provider:
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified, or accredited as required by state law.

Reconstructive Surgery:
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Rehabilitation Services:
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care:
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist:
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Usual, Customary and Reasonable (UCR):
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

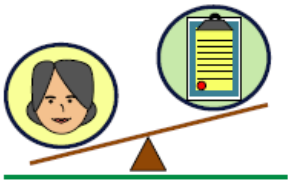
Urgent Care:
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

You and Your Insurer Share Costs: Example

Jane's Plan Details:
Deductible: $1,500
Co-insurance: 20%
Out-of-Pocket Limit: $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



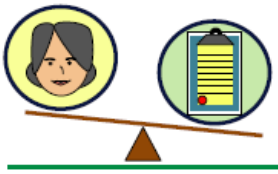
Jane pays **100%** | Her plan pays **0%**

Jane hasn't reached her $1,500 deductible yet.

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jan Pays: $125
Her plan pays: $0

more costs



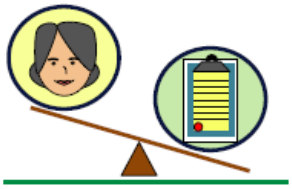
Jane pays **20%** | Her plan pays **80%**

Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane Pays: 20% of $75
Her plan pays: 80% of $75

more costs



Jane pays **0%** | Her plan pays **100%**

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane Pays: $0
Her plan pays: $200

Customer Service Contacts		
Vendor	**Phone Number**	**Access Information**
Unified Group Services (Medical & Rx Drugs)	1.800.291.5837	www.unifiedgrp.com
Rx Help Center (Specialty Drugs)	1.866.478.9593	http://rxc8290368.rxhelpcenters.com
Unified Group Services (Dental)	1.800.291.5837	www.unifiedgrp.com
UMB Financial Corp. (HSA)	1.866.520.4472	www.umb.com
Kansas City Life (Vision)	1.800.877.7195	www.vsp.com
Kansas City Life (STD & LTD)	1.888.305.0590	www.kcl.com / email claims@disabilityrms.com
Kansas City Life / KEPRO (EAP)	1.877.239.8783	www.eaphelplink.com
Reliance Standard Products	1.800.351.7500	www.reliancematrix.com
Nationwide (Pet Insurance)	1.877.738.7874	www.petsnationwide.com

DISCLAIMER: This guide describes some of the benefit plans available to you as an employee of GEO Academies. It is not a Summary Plan Description, and it does not provide all the details. The details of these plans are contained in the official Plan Documents, including some insurance contracts. If there are discrepancies between the information in this guide and the official Plan Documents, provisions of the Plan Documents will govern. GEO Academies reserves the right to terminate