Gestalt
COMMUNITY SCHOOLS

2024

EMPLOYEE BENEFITS

Welcome!

We are committed to providing competitive benefit programs that are flexible enough to meet your individual needs.

Our comprehensive benefits are carefully designed to give you the tools you need to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement.

Getting the most from your benefits is up to you. You know your family, your goals and your lifestyle best. This benefits guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family and be sure to act before the enrollment deadline.

If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to Human Resources.

Enrollment Dates

07/31/24 – 08/8/24

Eligibility

Benefit Eligibility

You and your eligible family members may participate in the 2024 employee benefits program if you're a regular, full-time employee working a minimum of 30 hours per week.

Dependent Eligibility

You can enroll the following dependents in our group benefit plans:

- Your legal spouse
- Children up to age 26*
- A child under the age of 26 who is your natural child, stepchild, legally adopted child, or child for whom you have obtained legal guardianship
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

***Enrolled children lose coverage when they turn 26. You must inform HR 30 days prior to your dependent reaching their 26th birthday.**

New-Hire Eligibility

New hires can join the plan the first of the month following 30 days. Spouses and dependent children of the employee are also eligible to participate in our benefit plans, if you are a full-time employee.

Qualifying Life Event

Your benefit elections made during Open Enrollment will be effective 09/01/2024. You may not make changes to your elections unless you experience a qualifying life event.

Common qualifying events include:

- Change in the number of your dependents (through birth or adoption or if a child is no longer an eligible dependent)
- Change in spouse's employment status (resulting in a loss or gain of coverage)
- Change in legal marital status (marriage, divorce, or legal separation)
- Change in employment status from full-time to part-time or part-time to full-time, resulting in a gain or loss of eligibility
- Eligibility for coverage through the Marketplace
- Entitlement to Medicare or Medicaid
- A court order to provide health coverage for your eligible dependent (QMSCO)

Some lesser-known qualifying events are:

- Turning 26 and losing coverage through a parent's plan
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

IMPORTANT

If you need to make a change before the next Open Enrollment period due to a change in status, you must submit the required documentation WITHIN 30 or 60 DAYS depending on the type of the qualifying life change event.

Choose Your Medical Plan

Register Online

Your connection to great healthcare is only a click away. Register for an online account at www.umr.com so you can access time-saving tools, tips for healthy living, view lab results, choose a doctor, manage your EOBs, and more!

Download the Mobile App

With the UMR mobile app, you've got the tools you need to manage your healthcare all from your smartphone. The mobile app is available in the Apple and Google Play store.

Download the UMR app today!
Simply scan the QR code or visit your app store to get started.

Understanding Your Plan

Your medical plans will be offered through UMR. Please review your plan summaries or SBCs for coverage information and full plan details located on the Ben360/Employee Navigator portal.

Elections you make during Open Enrollment will be effective 09/01/2024 and remain in effect until 08/31/2025 unless you experience a Qualified Life Event.

You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs. In-network providers charge members reduced, contracted rates instead of their typical fees. Providers outside the plan's network set their own rates, so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.

Buy Up Plan: $500 (individual) / $1,000 (family)

Each family member has an individual deductible in addition to the overall family deductible. This means that, if an individual in the family reaches their deductible before the family deductible is reached, their services will be paid by the insurance company.

Standard Plan: $1,500 (individual) / $3,000 (family)

Each family member has an individual deductible in addition to the overall family deductible. This means that, if an individual in the family reaches their deductible before the family deductible is reached, their services will be paid by the insurance company.

Base Plan: $3,500 (individual) / $7,000 (family)

All family members' out-of-pocket expenses count toward the family deductible until it is met. It doesn't matter if one person incurs all the expenses that meet the deductible or if two or more family members contribute toward meeting the family deductible.

UMR℠
A UnitedHealthcare Company

Medical Plan Comparison

UMR A UnitedHealthcare Company	Buy Up Plan		Standard Plan		Base Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
PLAN FEATURES						
Annual Deductible (Individual/Family)	$500 / $1,000	$1,000 / $2,000	$1,500 / $3,000	$3,000 / $6,000	$3,500 / $7,000	$7,000 / $14,000
Annual Out-of-Pocket Maximum (Individual/Family)	$1,500 / $3,000	$3,000 / $6,000	$5,850 / $11,700	$11,700 / $23,400	$8,500 / $17,000	$17,000 / $34,000
YOUR COSTS FOR CARE						
Preventive Care	$0	Not Covered	$0	Not Covered	$0	Not Covered
Coinsurance	80%	60%	80%	60%	80%	60%
Primary Care Physician (PCP)	$20 Copay	40%*	$30 Copay	40%*	$30 Copay	40%*
Virtual Visits	$0	Not Covered	$0	Not Covered	$0	Not Covered
Specialist Visit	$40 Copay	40%*	$50 Copay	40%*	$50 Copay	40%*
Urgent Care	$75 Copay	40%*	$75 Copay	40%*	$75 Copay	40%*
Emergency Room	$250 Copay		$350 Copay		$350 Copay	
Prescription Drugs - Category 1 (generic) - Category 2 (preferred) - Category 3 (non-preferred)	$10 $35 $60	Not Covered	$10 $35 $60	Not Covered	$15 $40 $70	Not Covered

* After deductible

** This is a summary of benefits and not a guarantee. Benefit payments are subject to all plan provisions and eligibility requirements at the time services are rendered. The plan document and summary plan description are the official sources of information. In the event of a discrepancy, the plan document and summary plan description will prevail.

https://www.brainshark.com/oswaldcompanies/vu?pi=zIKznVdqIzhkDAz0

Gestalt
COMMUNITY SCHOOLS

Gestalt Community Schools believes our team members should be able to embrace holistic wellness using Gestalt Community Schools Natural Health Program.

The program allows you to submit reimbursement for up to $600 annually, between September 1, 2024 to December 31, 2025, for the therapies listed below.

Gestalt Community Schools Natural Health Program

All natural health providers must have a Tax ID number and provide a receipt describing the procedure/service provided.

Submitted receipts must be dated between September 1, 2024 to December 31, 2025. Submit receipts to isbc@umr.com and hr@gestaltcs.org.

Questions?

If you have any questions, please contact human resources for clarification.

Approved Reimbursements

- Cryogenic Immersion
- Sauna Therapy
- Massages
- Homeopathy
- Float Therapy
- Tai Chi
- Reiki
- Meditation Therapy
- Biofeedback
- Hypnosis
- Electromagnetic Therapy

Cosmetic procedures will NOT be reimbursed under the Gestalt Community Schools Natural Health Program.

Ross & Yerger
INSURE THE FUTURE

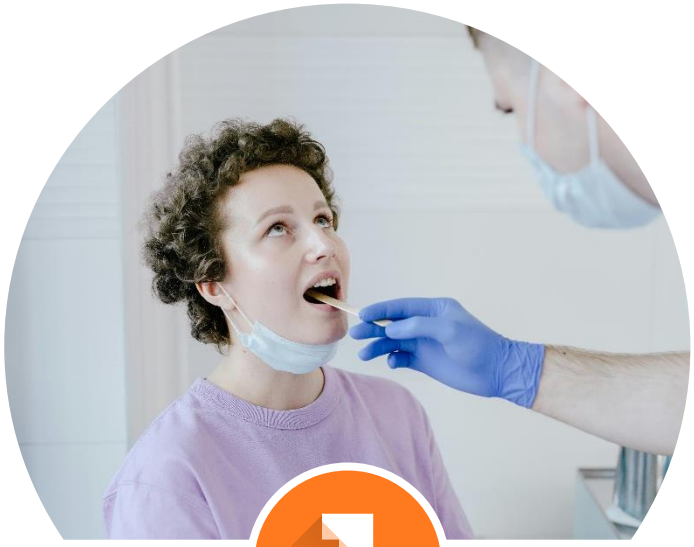
UMR

Knowing Where To Go For Care

With many options for getting care, how do you choose? This chart will help you understand the differences between your options and how you can save money.

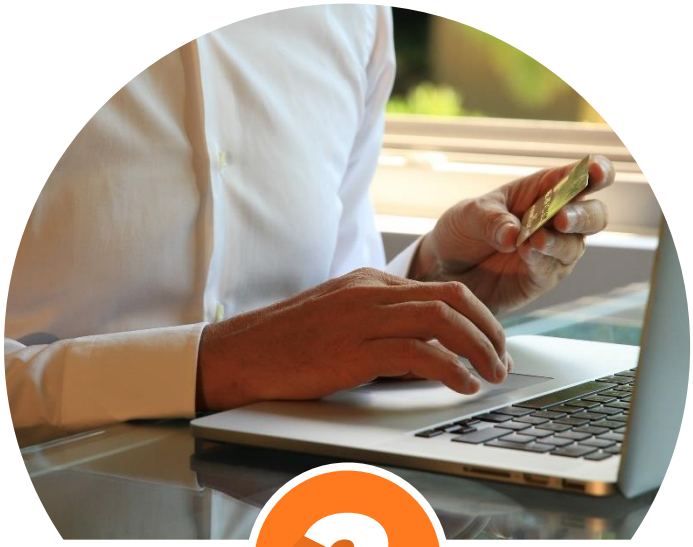
WHERE TO GET CARE	WHAT IT IS	TYPE OF CARE		COST
Virtual Visit	A virtual visit lets you see a doctor via your smartphone, tablet, or computer. Sign in to [provider] and choose from provider sites where you can register for a virtual visit	Allergies Pink eye Bladder infections Rashes Bronchitis	Seasonal flu Coughs/colds Sore throats Diarrhea Stomach aches Fever	$
Convenience Care Clinics	Visit a convenience care clinic when you can't see your doctor and your health issue isn't urgent. These clinics are often in stores	Common infections (e.g., strep throat) Minor skin conditions (e.g., poison ivy)	Vaccinations Pregnancy tests Minor injuries Ear aches	$$
Primary Care Physician	Go to a doctor's office when you need preventive or routine care. Your primary doctor can access your medical records, manage your medications, and refer you to specialists, if needed	Checkups Preventive services Minor skin conditions Vaccinations General health management		$$
Urgent Care	Urgent care is ideal for when you need care quickly, but it's not an emergency (and your doctor isn't available). Urgent care centers treat issues which aren't life threatening	Sprains Strains Small cuts which may need a few stitches Minor burns/infections/broken bones		$$$
Emergency Room	The ER is for life threatening or very serious conditions which require immediate care. This is also when to call 911	Heavy bleeding Large open wounds Sudden change in vision Chest pain Sudden weakness or trouble talking	Major burns Spinal injuries Severe head injury Breathing difficulty Major broken bones	$$$$

Understanding How Your Plan Works



1

Your family visits your provider (doctor/hospital) and shows their medical insurance card.



2

Your Doctor or provider will bill your medical carrier.

3

Your medical carrier will process your claim, notify your provider, and send a Claims Summary to you and your provider.

4

Explanation Of Benefits (EOB) You are responsible to pay the amount due to your provider as shown on your EOB.

Dental Plans

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings and x-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Dental coverage is offered for basic and major services. The dental plan also includes 100% coverage for preventive care. You and your eligible dependents may enroll in one of the three dental coverage options administered by SunLife.

Sun Life Financial	BASIC PLAN		ENHANCED PLAN		PRE-PAID PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
PLAN FEATURES						
Annual Maximum Per Person	$1,000	$1,000	$2,000	$2,000	Copay Schedule	Not Covered
Preventive Care Routine Cleanings, Exams (twice a year)	100%	100%*	100%	100%*	Varies	Not Covered
Basic Services Fillings, Routine Extractions	80%	80%*	80%	80%*	Varies	Not Covered
Major Services Crowns, Dentures, Bridges	50%	50%*	60%	60%*	Varies	Not Covered
Orthodontia Adults and Children	N/A	N/A	50%	50%*	Not Covered	Not Covered

*Out-of-network allowances are based on usual, customary, and reasonable charges (UCR).

**Basic and Major Services $50 individual/$150 family deductible, excludes pre-paid dental plan.

https://www.sunlife.com/findadentist

Download the app

Vision Plan

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Your vision insurance is provided by SunLife and entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

www.sunlife.com/onlineadvantage

Download the app

Sun Life Financial

Vision Plan (Signature Network)	In Network	Out of Network
Eye Exam (Once Every 12 Months)	$10 copay	Up to $52
Lenses (Once Every 12 Months) Single Vision - Bifocal - Trifocal - Lenticular -	 $25 copay $25 copay $25 copay $25 copay	 Reimbursed up to $55 Reimbursed up to $75 Reimbursed up to $95 Reimbursed up to $125
Frames (Once Every 24 Months)	Up to $130 allowance: plus 20% off any amount above allowance	Reimbursed up to $57
Contact Lenses* (Once Every 12 Months) Medically Necessary - Elective -	 Covered after $25 Copay $130 Allowance	 Reimbursed up to $210 Reimbursed up to $105

*In lieu of glasses

Sun Life Financial

Group Life Insurance

Basic Life and Accidental Death and Dismemberment (AD&D)

The Basic Life and AD&D plan provides a benefit in the event of your death, dismemberment or paralysis. This benefit is sponsored by Gestalt Community Schools, so you will automatically be enrolled at no cost to you. Your coverage will be a fixed amount of 2 times your Basic Annual Earnings, up to a maximum of $50,000. Please make sure to review your beneficiary information regularly.

Voluntary Life Benefits

Supplemental Life Insurance

You may purchase additional life insurance at group rates:

- Available in increments of $10,000 up to $500,000, not to exceed 5 times your Basic Annual Earnings.
- You pay the full cost of this plan and the amount deducted depends on the age of the employee and the amount of coverage elected
- If you do not elect this coverage when first becoming eligible or an election over $200,000 is made, you are subject to medical underwriting by the carrier

Spousal and Child Life Insurance

You may purchase additional dependent life insurance at group rates:

- Spousal and child cover is only available in addition to voluntary employee cover
- Spousal life is available in increments of $5,000 up to a max of $250,000 or 100% of the employee amount
- Spousal life can be elected up to $50,000 without medical underwriting as a new hire
- Child life is available in increments of $2,000 up to $10,000 not to exceed 100% of your coverage amount.
- Children are not subject to medical underwriting
- The cost remains the same regardless of the number of children you have

Guaranteed Issue and Evidence of Insurability

Employees and spouses who elect Voluntary Life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI).

If the amount requested is more than the GI, you will need to provide EOI before the amount over GI becomes effective.

For those who previously waived coverage or those who wish to increase their cover you will need to provide EOI.

Imputed Income

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds $50,000 and is subject to federal income, Social Security and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

Disability Coverage

We want to do everything we can to protect you and your family. That's why Gestalt Community Schools pays for the full cost of short-term disability insurance - meaning that you owe nothing out of pocket.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note that you are not eligible to receive long-term disability benefits if you are receiving workers' compensation benefits.

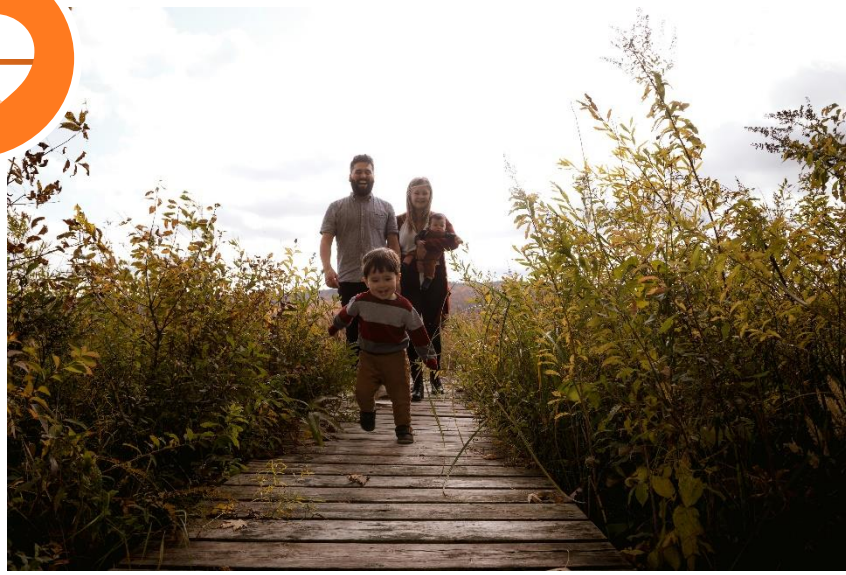
Long-Term Disability (LTD) Plan

The LTD plan provides full-time employees with income replacement in the amount of 60% of your total monthly earnings up to a maximum of $5,000/month while disabled and unable to work due to a non-occupational illness or injury, including pregnancy.

Filing a Long-Term Disability Claim

In order to receive benefits, you must report your disability claim to SunLife if you will be out of work for at least 180 days from the date of your disability.

You can contact SunLife by phone or website. Contact info can be found on contact list page of this booklet.



Sun Life Financial

Employee Contributions

UMR A UnitedHealthcare Company	BASE PLAN	STANDARD PLAN	BUY UP PLAN
Medical Premiums Per Pay Period			
Employee Only	$0.00	$55.86	$79.90
Employee + Spouse	$88.84	$117.30	$167.79
Employee + Child(ren)	$80.38	$106.13	$151.81
Employee & Family	$126.98	$167.58	$239.70

Sun Life Financial	BASIC PLAN	ENHANCED PLAN	PRE-PAID PLAN
Dental Premiums Per Pay Period			
Employee Only	$11.72	$19.48	$7.13
Employee + Spouse	$23.86	$39.43	$11.61
Employee + Child(ren)	$30.82	$45.95	$15.76
Employee + Family	$41.46	$73.08	$18.49

Sun Life Financial	VISION PLAN
Vision Premiums Per Pay Period	
Employee Only	$4.99
Employee + Spouse	$9.72
Employee + Child(ren)	$10.55
Employee + Family	$16.58

Benefits Definitions

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance 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 coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (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.)

High-Deductible Health Plan (HDHP)

A type of health plan that has lower monthly premiums, but higher deductibles and out-of-pocket limits, than a traditional health plan.

HDHPs are often coupled with an HSA (Health Savings Account)

Network

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

In-Network Provider

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Out-of-Network Provider

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Benefits Definitions

Out-of-Pocket Maximum

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

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.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician

assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Referral

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Important Contacts

Coverage	Contact	Phone	Website
Medical	UMR	(800) 826 – 9781	www.umr.com
Dental (Group#915682)	SunLife	800-247-6875	www.sunlife.com/us
Vision (Group#915682)	SunLife / VSP	800-786-5433	www.vsp.com
Basic Life & AD&D (Group#915682)	SunLife	800-247-6875	www.sunlife.com/us
Voluntary Life & AD&D (Group#915682)	SunLife	800-247-6875	www.sunlife.com/us
Long Term Disability (Group#915682)	SunLife	800-247-6875	www.sunlife.com/us
Ross & Yerger Client Manager	Heather Allen	(601) 944-0952	hallen@rossandyerger.com
Ross & Yerger Producer	Will Garner	(601) 944-0960	wgarner@rossandyerger.com
Ross & Yerger Producer	Marcus Burger	(601) 944-9701	mburger@rossandyerger.com

Gestalt Community Schools

TAKE TIME TO REVIEW YOUR BENEFITS

Your benefits review is the best opportunity of the year to make changes to your benefits package and ensure your coverage continues to meet your needs. An American Fidelity account manager can help you review your coverage and find a plan that works best for you and your family.

Your enrollment dates:

August 1,2024
August 31, 2024

Schedule your appointment today:

https://enroll.americanfidelity.com/B6FC3673

Has your information changed?

New address or bigger family? A lot can change in a year and it's important to verify all of your information is up to date during your benefits review.

Available Benefits:

Disability Insurance
americanfidelity.com/disability

Cancer Insurance
americanfidelity.com/cancer

Accident Insurance
americanfidelity.com/accident

Critical Illness Insurance
americanfidelity.com/critical-illness

Life Insurance
americanfidelity.com/life

403(b) Plans
americanfidelity.com/annuities

Limitations, exclusions and waiting periods may apply.

Candice Chalmers
Senior Account Executive
North Mississippi Branch Office
126 South Flicker Street
Memphis, TN 38104
800- 465-2129 · 901-458-9252
candice.chalmers@americanfidelity.com

AMERICAN FIDELITY
a different opinion

americanfidelity.com

These notices are being provided to make certain that you understand your right to apply for group health coverage. You should read the notices even if you plan to waive health coverage at this time.

Loss of Other Coverage

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

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

Marriage, Birth, or Adoption

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

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

Medicaid or CHIP

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

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

HIPAA 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 you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Employer Representative.

Summary of Benefits and Coverage

Health plans are required to provide members with a Summary of Benefits and Coverage (SBC). The SBC is different from the standard summary, in that it provides members with improved standardized information designed to help better understand your coverage and compare the options available to you.

Patient Protection

If the Group Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre- approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website. It is your responsibility to ensure that the information provided on your application for coverage is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage based on fraud or misrepresentation.

Women's Health and Cancer Rights Act of 1998

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. If you would like more information on WHCRA benefits, call your plan administrator.

Michelle's Law

Michelle's Law was enacted in 2008 to ensure that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law is named after a New Hampshire college student, Michelle Morse, who continued her studies while battling colon cancer in order to maintain health insurance coverage under her parents' plan. Michelle died of colon cancer in November 2005 at the age of 22. The Affordable Care Act (ACA) further expanded coverage requirements for dependents, effective for plan years beginning on or after September 23, 2010. Under the ACA, group health plans or insurers that provide coverage for dependent children must continue to make coverage available until a child attains age 26, regardless of student status.

Coverage Requirements - Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under Michelle's Law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

Notice Requirements - If a group health plan requires a certification of student status for coverage under the plan, it must send a Michelle's Law notice along with any notice regarding the certification requirement. The Michelle's Law notice must be written in language understandable to a typical plan participant and must describe the terms of the continuation

coverage available under Michelle's Law during medically necessary leaves of absence.

Impact of the ACA - The ACA's adult child coverage mandate diminished the impact of Michelle's Law on many health plans. Under the ACA, if a group health plan or insurer provides dependent coverage for children, the plan or insurer must continue to make the coverage available until the child attains age 26, regardless of student status. The impact of Michelle's Law on group health plans will generally be limited to health plans providing coverage to dependent students age 26 or over.

The Newborns' and Mothers' Health Protection Act (NMHPA)
This was enacted in 1996 to provide protections to mothers and their newborn children with respect to the length of hospital stays after childbirth. Under the NMHPA, group health plans may not restrict mothers' and newborns' benefits for hospital stays after childbirth to less than:

48 hours following a vaginal delivery; and
96 hours following a delivery by cesarean section.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay relating to 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).

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

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

- 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.
- The Group Health Plan has determined that the prescription drug coverage offered by your Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).
Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

COBRA Continuation of Coverage
The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice, to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

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.

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, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.
If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums.
The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY:711 Email: masspremassistance@accenture.com
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: 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
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki HawkiPhone:1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-657-3739 Email:HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaidhotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
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.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	**SOUTH DAKOTA - 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: http://dss.sd.gov Phone: 1-888-828-0059

NEW YORK – Medicaid	TEXAS – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.dmas.virginia.gov/learn/premium-assistance/famis-select CHIP Website: https://www.coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premiums-payment-hipp-programs Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Phone: 1-800-986-KIDS (5437) CHIPP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	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)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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.,

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace is where you can get coverage through the Marketplace for 2023 if you qualify or for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. [1]

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

How Can I Get More Information?

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

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

PART B: Information about Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)	
Gestalt Community Schools		
5. Employer address	6. Employer phone number	
2650 Thousand Oaks Blvd, Suite 2200	(901)549-2734	
7. City	8. State	9. ZIP code
Memphis	TN	38118
10. Who can we contact about employee health coverage at this job? (expires 6-30-2024)		
Jaleesa Oniovos		
11. Phone number (if different from above)	12. Email address	
	joniovos@gestaltcs.org	

Here is some basic information about health coverage offered by this employer:
As your employer, we offer a health plan to:

- ☒ All employees. Eligible employees are: Full-time working 30+ hours per week
- ☐ Some employees. Eligible employees are: All Full-time Eligible Employees

With respect to dependents

- ☒ We do offer coverage. Eligible dependents are: Spouse and Dependents of employees up to age 26;
- ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.
The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.

If you have any questions about this summary, contact Human Resources.[i]

[i] **Note:** While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.

Gestalt
COMMUNITY SCHOOLS