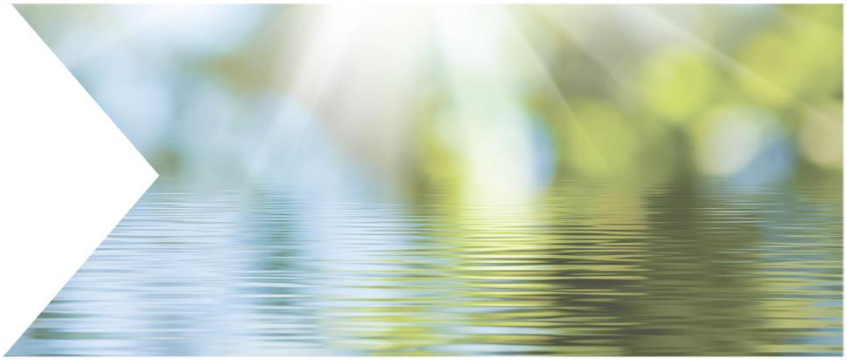
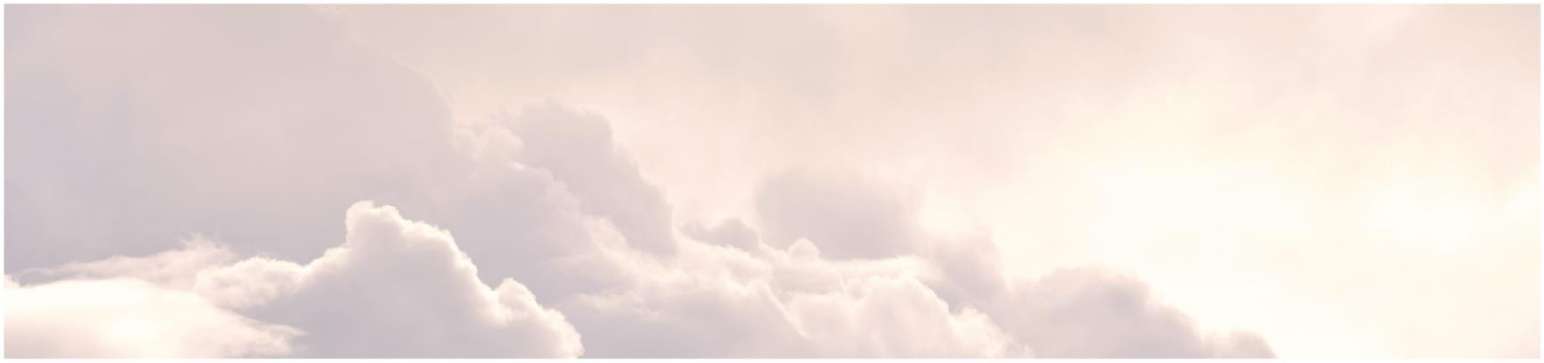
2025

Benefits Information Guide

LEMAN ACADEMY of EXCELLENCE

Arizona





Discover Your Benefits

Let's explore your benefit plan options, programs and resources.

Access your benefits from anywhere, anytime!

iNGAGED

Available for iOS and Android mobile devices, the iNGAGED app makes checking your health and benefits information easier than ever!

With iNGAGED, you can view our company's benefit plans and resources, access policy information and group numbers, quickly contact an insurance carrier, keep up with important benefit plan announcements, and store images of your ID cards directly in the app.

Download the "iNGAGED Benefits" app from the App Store or Google Play or go to https://ingagedbenefits.com/login and use company code Leman to login.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 2 months, Federal law gives you more choices about your prescription drug coverage. Please see page 42 for more details.

Eligibility & Enrollment

Eligibility & Enrollment

Time to answer some questions…

Who can enroll?

If you are an employee that is expected to regularly work a minimum of 30 hours per week, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) and/or eligible children.

An employee may be unable to pay for and/or receive employer contributions on a pre-tax basis for the cost of the benefits of an employee's state registered domestic partner that does not meet the definition of the employee's tax dependent under IRC Section 152.

When does coverage begin?

Regular, full-time employees: You are eligible to enroll on your date of hire, but your coverage will not be effective until the first of the month following your date of hire.

Your enrollment choices remain in effect through the end of the benefits plan year, August 1, 2025 – July 31, 2026. If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status event during the plan year. Please check with your plan administrator and your Section 125 plan document on any applicable status change events that would allow you to make a mid-year election change.

How do I get started with my enrollment?

paylocity

Available as an app within the App Store or GooglePlay!

- Log into your Paylocity Self Service Portal at https://access.paylocity.com.
- In the applications menu at the top left, select Benefits.
- Click the" Enroll Now" button to begin your benefits enrollment.

What if my needs change during the year?

You are permitted to make changes to your benefits after the open enrollment period if you have a change in status event as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the status change event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's loss or gain of coverage through our organization or another employer.
- An employee (1) was expected to average at least 30 hours of service per week, (2) has a change in employment status where he/she will reasonably be expected to average less than 30 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage).
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange due to open enrollment or special enrollment period, and coverage is effective no later than the day immediately following the revocation of your employer-sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of status change events, please refer to the "Legal Information Regarding Your Plans" contents.

Do I have to enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as from a State or Federal Health Insurance Exchange.

For information regarding Healthcare Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov.

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. To waive coverage, logon to the Paylocity Web Benefit System and waive coverage. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be during the next open enrollment in 2026, unless a change in status event occurs.

Health Advocate

To support you and your family in navigating the healthcare system and maximizing your benefits, the services offered by Health Advocate can assist with healthcare issues and treatment decisions and address time-consuming claims or other concerns.

Administrative Support

- Explain coverage and coordinate benefits.
- Research and resolve insurance claims and medical billing issues.
- Identify leading in-network doctors using proprietary MEDIS quality care evaluation approach and make appointments.
- Facilitate any required pre-authorizations for medical services, durable medical equipment and prescription drugs.
- Research ways to reduce prescription drug and other costs.
- Facilitate the transfer of medical records between physicians.

Clinical Decision Support

- Answer questions about medical diagnoses and review treatment options.
- Research and identify the latest, most advanced approaches to care.
- Coordinate clinical services related to medical care and identify top experts and Centers of Excellence across the country for initial consults and second opinions.
- Discuss the cost and quality of medical services to help members make informed decisions.
- Help employees prepare for doctor visits, review results and plan future actions.

Contact your personal Health Advocate Monday through Friday between 8:00 a.m. and 10:00 p.m. Eastern time, toll-free at 866.695.8622.

Health Advocate can also be accessed 24/7 via email or by their website.

- Email: answers@HealthAdvocate.com
- Web: HealthAdvocate.com/members

Medical

Medical

Which plan type is right for you?

PPO	HDHP
A Preferred Provider Organization (PPO) Plan contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Using providers that belong in the plan's network will provide a higher benefit, but you have the flexibility to see a provider outside the network, generally for an additional cost.	A High-Deductible Health Plan (HDHP) combines traditional medical coverage with a Health Savings Account (HSA). As evident by the name, this plan has a higher deductible you must reach before the plan kicks in.
• Broader choice of providers. • No referrals required for specialists.	• Tax advantages with an HSA. • Lower monthly premiums.
You'll be responsible for copays and coinsurance, but your deductible will be lower than the HDHP plan.	Your out-of-pocket expenses may be mostly upfront, since you'll need to satisfy your deductible before your plan kicks in.
… you prefer flexibility and provider options, and if you're comfortable paying more out of your paycheck and less out of pocket for your deductible.	… you don't usually need much care throughout the year, this plan might be right for you. Make sure you have funds set aside to pay towards the deductible.
You may choose in or out-of-network care. However, in-network care provides you a higher level of benefit.	It is beneficial to keep records of your healthcare expenses by retaining your receipts.

Please note, the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit https://www.azblue.com.

Benefits Information on the Go

Blue Cross Blue Shield of Arizona's Mobile Website!

BCBSAZ's mobile application will help you manage your health care easier and faster! Use the app to:

- Search for Quick Care, either urgent care or emergency room services
- View and share your member ID card.
- Access your account balance and check the status of benefit amounts, such as your deductible and out-of-pocket maximum.
- View the latest claims for your plan.

Go to https://www.azblue.com to get started!

How to Find a Provider

Blue Cross Blue Shield of Arizona

1. Go to https://www.azblue.com and select **Find Care**.
2. Choose **Browse the network as a guest**, and then click on the box that reads **Continue as a guest**.
3. Click on the arrow next to **Type of Coverage** and select the type of plan.
4. Select from **Type of Provider** and **Network** from the drop-down menu, and then click **Search**.
5. Click on **Choose a location** and type your information in the box or select **Use my current location**. You can then search **Doctors by Name, Doctors by Specialty**, and more.

Stay connected with AZ Blue. Create your MyBlue account:
Visit https://identity.azblue.com/member-login to create a MyBlue account, where you can:

- View plan information
- Find a provider
- Access your digital ID card
- View and track claims and deductibles
- Explore care options and estimate cost
- View your member guide, your benefit book, Summary of Benefits and Coverage, and more

Remember, if you don't log in or create an account, you may get search results showing healthcare facilities and professionals that are not in your plan's network.

https://www.azblue.com is your personalized member website to help you access and manage medical, dental and vision plan information 24/7. Sign in to AZBlue.com to find the most accurate network information.

Prescription Drug (Rx) Benefits – OptumRx

Many FDA-approved prescription medications are covered through the benefits program. Tiered prescription drug plans require varying levels of payment depending on the drug's tier.

Generic formulary (Tier 1): Generic drugs contain the same active ingredients as their brand-name counterparts but are less expensive.

Brand name medications (Tier 2): A brand-name medication can only be produced by one specified manufacturer and is proven to be the most effective in its class.

Non-formulary prescriptions (Tier 3): Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list. This is because there is an alternative proven to be just as effective and safe, but less costly. Ask your doctor or pharmacist for additional information regarding the generic option.

Specialty prescriptions (Tier 4): Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

Access your pharmacy benefits online at https://www.azblue.com/pharmacy/open-drug-list

Why pay more for prescriptions?

Use Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply from a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. Call ahead to determine which pharmacy provides the most competitive price.

Over-the-Counter Options

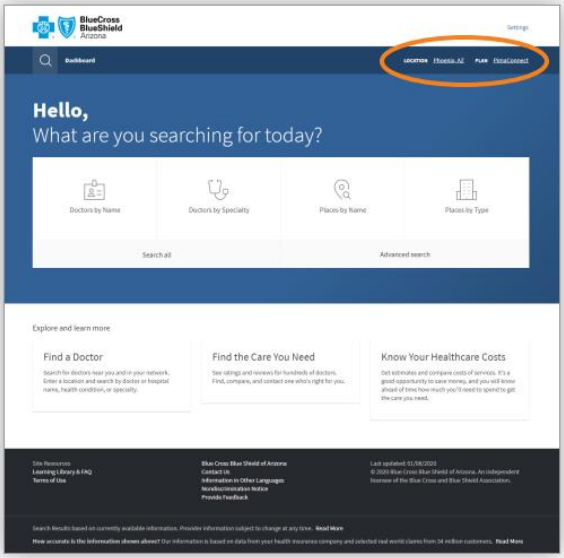
For common ailments, over-the-counter drugs may provide a less expensive alternative that serves the same purpose as prescription medications.

The PimaConnect network from Blue Cross® Blue Shield® of Arizona (BCBSAZ) delivers on our commitment to improve care quality and create a better healthcare experience—while lowering costs.

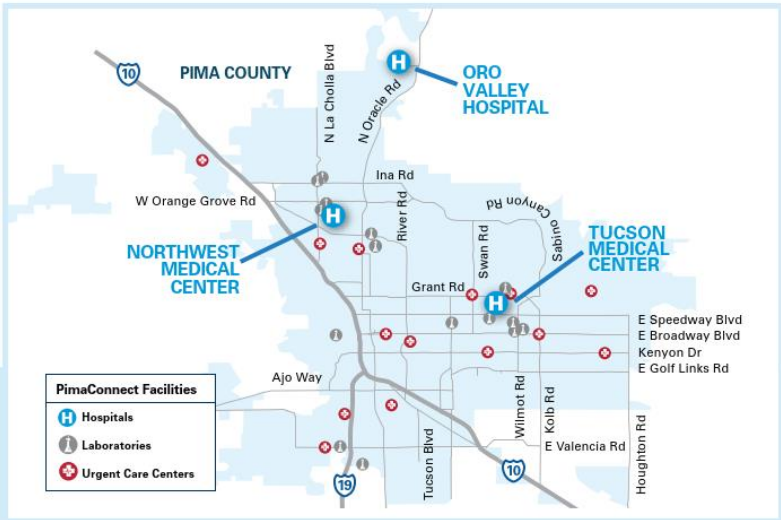
A network of doctors and hospitals that's close and convenient

- The PimaConnect network is for residents of Pima County.
- The network features doctors and hospitals from Tucson Medical Center and Northwest Healthcare.
- To keep your healthcare costs lower, it is important to use a participating lab or imaging service such as Sonora Quest Laboratories, LabCorp, ACP Imaging, and Radiology Ltd.
- Only providers contracted with the PimaConnect network are considered "in-network." Please check with your doctors, facilities, and other health professionals to make sure they are in the PimaConnect network before receiving care.
- Finding in-network care is easy with the **Find a Doctor** tool, available at **azblue.com/findadoctor.** Be sure to search for providers in the PimaConnect network, indicated in the top right of the search page.

Search with the Find A Doctor tool



PIMACONNECT NETWORK FACILITIES TUCSON METRO AREA[1]



[1] Providers as of January 2019 and subject to change.

See reverse side

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

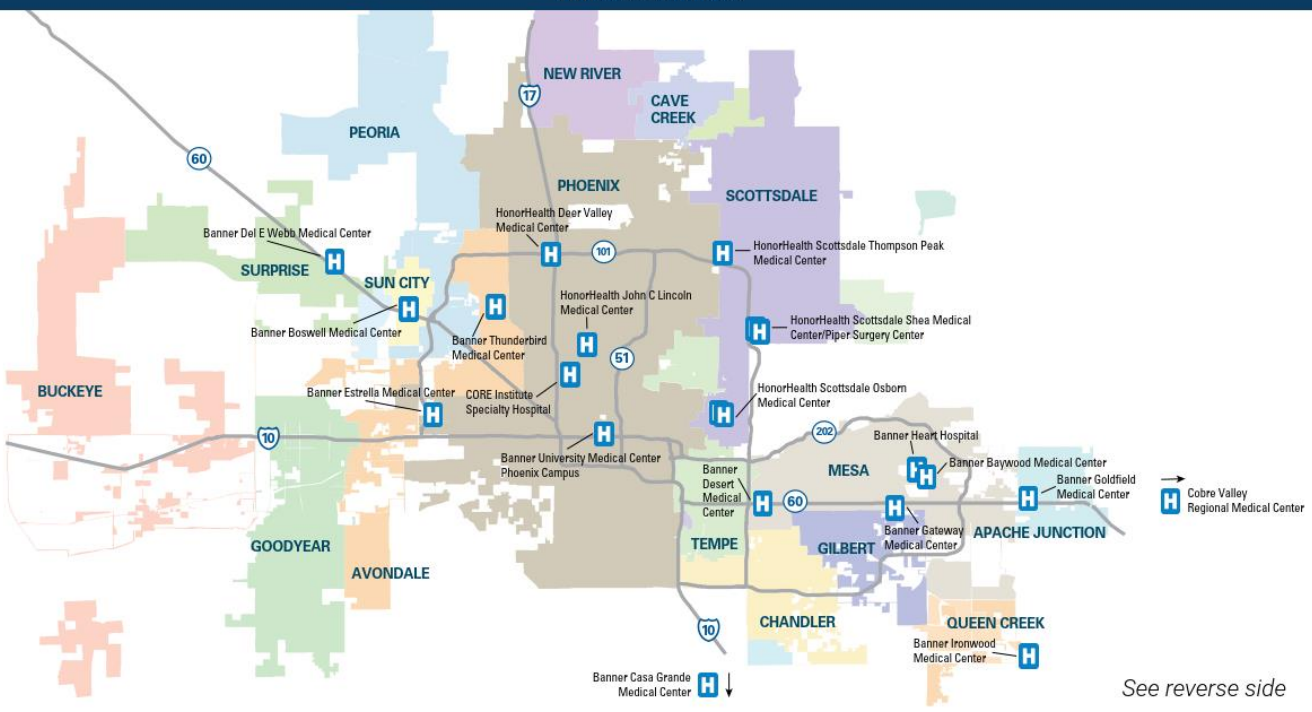
Discover the Alliance Network

The Alliance network from Blue Cross® Blue Shield® of Arizona (AZ Blue) delivers on our commitment to improve care quality and create a better healthcare experience—while lowering costs.

A network of doctors and hospitals that are close and convenient

- The Alliance network is for residents of Maricopa and Pinal counties.
- The network features doctors and hospitals affiliated with Banner Health and HonorHealth.
- To keep your healthcare costs lower, it is important to use a participating lab or imaging service such as Sonora Quest Laboratories, Banner Imaging, Southwest Diagnostic Imaging, and Sun Radiology.
- Only providers contracted with the Alliance network are considered "in-network." Please check with your doctors, facilities, and other health professionals to make sure they are in the Alliance network before receiving care.
- Finding in-network care is easy with the **Find a Doctor** tool, available at **azblue.com**/findadoctor. Be sure to search for providers in the Alliance network, indicated at the top right of the search page.

Alliance Network



See reverse side

Need to see a doctor on demand?

Virtual Visits through BlueCare Anywhere

With telehealth, you can connect with leading board-certified physicians for many non-emergency illnesses through the internet, video chat or telephone. By leveraging these virtual visits, you can avoid emergency rooms or urgent care centers and quickly refill your prescriptions so you can get back on your feet in no time.

Skip the waiting rooms and scheduling hassles. Telemedicine services through BCBSAZ, puts you in control of when and where you access care. You may speak with a licensed physician, psychologist, or psychiatrist 24/7/365 via phone or computer. Phone consultations and online video visits give you direct access to a licensed medical professional who may be able to:

- Define treatment of common medical conditions, such as colds, flu, bronchitis, allergies, rashes, depression, and more
- Provide specialist referrals
- Prescribe medication

To learn more or start a Virtual Visit, go to AZBlue.com

Three Types of Telehealth Care Available

MEDICAL

When an employee doesn't have a regular doctor or their primary care provider isn't available, BlueCare Anywhere providers are here to help with a range of common illnesses, aches, and pains. They can also prescribe medication, if necessary.

COUNSELING

Licensed psychologists or counselors are available to treat issues—such as mental health and substance use—that can affect emotional, psychological, and social well-being. By appointment only.

PSYCHIATRY

Board-certified psychiatrists are available for assessments, evaluation, treatment, and can prescribe medication. By appointment only.

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

I need specific medical care! How much does it cost?"

Plan Highlights	BCBSAZ PPO $4,000 Alliance/PimaConnect		BCBSAZ PPO $3,000 Alliance/PimaConnect	
	In-network Alliance/PimaConnect	Out-of-Network	In-network Alliance/PimaConnect	Out-of-network
Annual Calendar Year Deductible				
Individual	$4,000	$10,000	$3,000	$10,000
Family	$8,000	$20,000	$6,000	$20,000
Maximum Calendar Year Out-of-pocket [1]				
Individual	$8,150	$20,000	$8,150	$20,000
Family	$16,300	$40,000	$16,300	$40,000
Professional Services				
Primary Care Physician (PCP)	$10 copay	50% after deductible	$10 copay	50% after deductible
Specialist	$95 copay	50% after deductible	$95 copay	50% after deductible
Telehealth Visit	$10 / $95	50% after deductible	$10 / $95	50% after deductible
Virtual Care Services (BlueCare Anywhere)	$10 or $20 copay	50% after deductible	$10 or $20 copay	50% after deductible
Preventive Care Exam	No Charge	50% after deductible	No Charge	50% after deductible
Diagnostic X-ray and Lab	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Complex Diagnostics (MRI/CT Scan)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic Services	$95 deductible	50% after deductible	$95 copay	50% after deductible
Hospital Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Facility Services	$350 access fee then 20% after deductible	$350 access fee then 50% after deductible	$350 access fee then 20% after deductible	$350 access fee then 50% after deductible
Outpatient Phyicians	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Urgent Care	$50 copay	50% after deductible	$50 copay	50% after deductible
Emergency Room	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Mental Health & Substance Abuse				
Inpatient & Partial Hospitalization	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	$10 or $95 copay	50% after deductible	$10 or $95 copay	50% after deductible
Retail Prescription Drugs (30-day supply)				
Tier 1	$10 copay	$10 copay	$10 copay	$10 copay
Tier 2	$50 copay	$50 copay	$50 copay	$50 copay
Tier 3	$100 copay	$100 copay	$100 copay	$100 copay
Mail Order Prescription Drugs (90-day supply)				
Tier 1	$25 copay	Not covered	$25 copay	Not covered
Tier 2	$125 copay	Not covered	$125 copay	Not covered
Tier 3	$250 copay	Not covered	$250 copay	Not covered

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

"I need specific medical care! How much does it cost?"

Plan Highlights	BCBSAZ HSA $3,300 Statewide		BCBSAZ PPO $2,500 Statewide	
	In-network Statewide	Out-of-network	In-network Statewide	Out-of-network
Annual Calendar Year Deductible				
Individual	$3,300	$10,000	$2,500	$10,000
Family	$6,600	$20,000	$5,000	$20,000
Maximum Calendar Year Out-of-pocket [1]				
Individual	$5,000	$20,000	$6,000	$20,000
Family	$10,000	$40,000	$12,000	$40,000
Professional Services				
Primary Care Physician (PCP)	20% after deductible	50% after deductible	$35 copay	50% after deductible
Specialist	20% after deductible	50% after deductible	$70 copay	50% after deductible
Telehealth Visit	20% after deductible	50% after deductible	$35 / $70 copay	Not Covered
Virtual Care Services (BlueCare Anywhere)	No Charge	50% after deductible	$10 or $20 Copay	50% after deductible
Preventive Care Exam	No Charge	50% after deductible	No Charge	50% after deductible
Diagnostic X-ray and Lab	20% after deductible	50% after deductible	$25 copay	50% after deductible
Complex Diagnostics (MRI/CT Scan)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic Services	20% after deductible	50% after deductible	$70 copay	50% after deductible
Hospital Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Facility Services	20% after deductible	50% after deductible	$350 access fee then 20% after deductible	$350 access fee then 50% after deductible
Outpatient Physician	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Urgent Care	20% after deductible	50% after deductible	$50 copay	50% after deductible
Emergency Room	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Mental Health & Substance Abuse				
Inpatient & Partial Hospitalization	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible	$35 or $70 copay	50% after deductible
Retail Prescription Drugs (30-day supply)				
Tier 1	$10 after deductible	$10 after deductible	$10 copay	$10 copay
Tier 2	$50 after deductible	$50 after deductible	$50 copay	$50 copay
Tier 3	$100 after deductible	$100 after deductible	$100 copay	$100 copay
Mail Order Prescription Drugs (90-day supply)				
Tier 1	$25 after deductible	Not covered	$25 copay	Not covered
Tier 2	$125 after deductible	Not covered	$125 copay	Not covered
Tier 3	$250 after deductible	Not covered	$250 copay	Not covered

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

"I need specific medical care! How much does it cost?"

Plan Highlights	BCBSAZ PPO $1,000 Statewide	
	In-Network Statewide	Out-of-network
Annual Calendar Year Deductible		
Individual	$1,000	$10,000
Family	$2,000	$20,000
Maximum Calendar Year Out-of-pocket [1]		
Individual	$5,000	$20,000
Family	$10,000	$40,000
Professional Services		
Primary Care Physician (PCP)	$25 copay	50% after deductible
Specialist	$50 copay	50% after deductible
Telehealth Visit	$25 / $50 copay	50% after deductible
Virtual Care Services (BlueCare Anywhere)	$10 or $20 Copay	Not Covered
Preventive Care Exam	No Charge	50% after deductible
Diagnostic X-ray and Lab	20% after deductible	50% after deductible
Complex Diagnostics (MRI/CT Scan)	20% after deductible	50% after deductible
Chiropractic Services	$50 copay	50% after deductible
Hospital Services		
Inpatient	20% after deductible	50% after deductible
Outpatient Facility Services	$350 access fee then 20% after deductible	$350 access fee then 50% after deductible
Outpatient Physician	20% after deductible	50% after deductible
Urgent Care	$50 copay	50% after deductible
Emergency Room	$400 copay	$400 copay
Mental Health & Substance Abuse		
Inpatient & Partial Hospitalization	20% after deductible	50% after deductible
Outpatient	$25 or $50 copay	50% after deductible
Retail Prescription Drugs (30-day supply)		
Tier 1	$10 copay	$10 copay
Tier 2	$50 copay	$50 copay
Tier 3	$100 copay	$100 copay
Mail Order Prescription Drugs (90-day supply)		
Tier 1	$25 copay	Not covered
Tier 2	$125 copay	Not covered
Tier 3	$250 copay	Not covered

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Download the "iNGAGED Benefits" app from the App Store or Google Play or go to https://ingagedbenefits.com/login and use company code **Leman** to login.

Employee Wellness

Employee Wellness

A healthier you starts here – mind and body!

Why Wellness?

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual healthcare costs. We care about your total well-being and encourage all employees to engage in our wellness resources at no-cost.

Wellness Program

BCBSAZ Sharecare

BCBSAZ has partnered with Sharecare, an award-winning digital health solution, to provide you simple tools to manage all your health and wellness needs in one place. You'll start by taking the RealAge health assessment to get a measure of the true age of your body in terms of health and vitality, versus your calendar age. The program then delivers personalized insights, challenges, daily tracking, and one-of-a-kind tools to help you reduce your RealAge and live healthier, no matter where you are in your health journey.

Features Include:

- RealAge Test
- Personalized Timeline
- Green Day Trackers
- Health Profile
- AskMD
- Challenges
- Rewards
- RealAge Program
- Lifestyle Coaching

Visit azblue.sharecare.com to get started!

Blue365 Deals

Blue365 give BCBSAZ members access to savings across all aspects of your life – including 20 percent of Fitbit devices, gym membership access starting at $19/month, discounts on healthy, organic meal delivery services from Sunbasket, and much more! Register now for free at www.Blue365Deals.com.

Blue365 Fitness your Way

Fitness Your Way® is your flexible, no-excuses fitness discount program brought to you by Blue Cross Blue Shield of Arizona

Enroll[1] in one of our flexible **gym packages** to work out at multiple gyms[2] where you live, work and travel, and take **virtual classes**.

Gym packages

- Starting at just $19 a month[3] and a one-time enrollment fee of $19[4]
- Access to thousands of gyms[2] nationwide with no long-term contracts
- Freedom to join as many gyms as you want
- All digital content included

At-home workouts

- Access to BurnAlong and LES MILLS[5]
- On-Demand videos available 24/7, from cycle classes to high-intensity workouts
- Live virtual classes including cardio, boot camps, barre, yoga and so much more
- Digital-only package also available[3]

Healthy living discounts[5]

- 20,000+ health and well-being specialists
- Up to 30% off services like acupuncture, chiropractic and nutritional counseling
- Additional discounts on vitamins, exercise equipment and more

Join Fitness Your Way now.

- Go to **www.blue365deals.com/fyw** to enroll in your preferred gym package and get your member ID number.
- Find participating gyms at **fitnessyourway.tivityhealth.com/locations**.
- Take your ID number to your preferred gym.
- Sign the gym's waiver, get your gym key fob and start working out.

Health Savings Account

Health Savings Accounts

Make your money work for you.

Health Savings Account (HSA)

By enrolling in the BCBSAZ High-Deductible Health Plan (HDHP), you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified healthcare expenses, such as your deductible, copayments, and other out-of-pocket expenses.

What to know about your Health Savings Account?

What to know about your Health Savings Account

What are the benefits?	• HSA funds can grow on a tax-free basis, subject to state law. Please consult your tax advisor for applicable tax laws in your state. • An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified healthcare expenses (tax regulations vary by state).
How do I become eligible to contribute to an HSA?	• You become eligible to contribute to an HSA if you are covered under a HDHP, you are not enrolled in non-qualified health insurance outside of Leman Academy's plan, you are not enrolled in Medicare, you are not claimed as a dependent on someone else's tax return (excluding a spouse), you have not received any hospital care or medical services from the Veterans Administration, in the last three months (unless these services were related to a service-connected disability) and you are not enrolled in a general Healthcare Flexible Spending Account (Health FSA) or a general Health Reimbursement Arrangement (HRA).

How do I get started?	• The most convenient way to pay for qualified expenses is to utilize the debit card. You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account. It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS. If you're ready to activate your HSA account, you can do so by:
	  ○ Step 1: Contact Human Resources if you are interested in enrolling in a Health Savings Account.
	  ○ Step 2: Human Resources will send you an Optum HSA Bank form to complete
	  ○ Step 3: Human Resources will send your form to Optum HSA Bank to open your account.
	• Once the HSA account is activated, you can manage and access your account at any time by visiting www.optumbank.com. If questions arise regarding account activation, contact Optum Bank or visit www.optumbank.com. Consult your tax advisor for taxation information or advice.

A few rules to keep in mind…	• For 2025, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $4,300 if you are enrolled in the HSA-PPO for employee-only coverage, and $8,550 for employees with dependent coverage. • It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax. • There is a 20% penalty for using HSA funds on non-qualified healthcare expenses if you are under age 65. For more details about what is considered a qualified healthcare expense, visit www.irs.gov. • Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon the maximum annual contribution limit for that calendar year, multiplied by the **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would be eligible to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first becomes HSA eligible on September 1st of that applicable year. However, under the Full-Contribution Rule, an employee is allowed to contribute the maximum annual contribution amount to his/her/their HSA, regardless of the number of months he/she/they were eligible to contribute to an HSA in that year, if he/she/they are eligible to contribute to an HSA on December 1 of the year and continues to be eligible to contribute to an HSA until December 31st of the following year (i.e., for all subsequent days until December 31st of the following year).

(1) Please consult your tax advisor for applicable tax laws in your state.

Download the "iNGAGED Benefits" app from the App Store or Google Play or go to https://ingagedbenefits.com/login and use company code **Leman** to login.

Supplemental Health Plans

Supplemental Health Plans

Be prepared for the unexpected.

Critical Illness Coverage

Critical illness coverage offered on a voluntary basis through Mutual of Omaha pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you, and you may use the funds as you see fit.

What can critical illness coverage pay for?

- Medical expenses, such as copays, deductibles or co-insurance
- Lost income
- Everyday expenses such as groceries and utilities
- Alternative treatments
- Lodging and travel to a specialist

What are examples of covered illnesses or conditions?

- Cancer
- Heart Attack
- Stroke
- Kidney Failure
- Organ Transplant

100% Employee-paid

If you elect the voluntary critical illness plan, 100% of the cost is deducted through payroll deductions.

- Premium rates are Age Banded. Please see Critical Illness summary for premium information.
- Age Reduction – 50% of the original amount at age 70. Coverage terminates at retirement.
- Pre-existing conditions exclusion 6 months prior to and 6 months following coverage effective date

Benefit options

Election	Minimum	Maximum	Guarantee Issue
Employee ($5,000 increments)	$5,000	$20,000	$20,000
Spouse ($1,000 increments)	$1,000	100% of employee's Principal Sum, up to $10,000	$10,000
Child(ren) Benefit for each child	25% of employee's Principal Sum, up to $5,000		All child amounts are guaranteed

*Employee must purchase coverage in order to purchase dependent coverage. Child insurance is automatic. A separate premium is not required.

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. View company benefits plans, resources and documentation, 24/7 Download the "iNGAGED Benefits" app from the App Store or Google Play or go to https://ingagedbenefits.com/login and use company code Leman to login.

Hospital Protection

Planned or unplanned, a trip to the hospital can be unsettling, especially if your primary medical insurance doesn't cover the majority of your costs. Hospital insurance offered on a voluntary basis through Mutual of Omaha pays out cash to you or your family to offset both medical and non-medical bills resulting from a hospital stay.

How can hospital insurance help?

The cash benefits can be used to pay for services or expenses your traditional medical plan might not cover. Since benefits are paid directly to you, you choose how to use them. Here are a few examples:

- Copayments
- Deductibles
- Transportation expenses
- Childcare
- Lodging expenses for a companion
- Lost income

Here's an example of how Hospital Insurance works

Meet Trevor. Trevor had some complications from gallbladder removal surgery, which resulted in a 5-day hospital stay. Through his primary medical insurance, Trevor owed a $500 deductible and $3,000 in co-insurance. With the help of his Hospital Insurance coverage, which paid a $1,000 admission benefit plus $150 for each additional day, he was only out of pocket $1,900 instead of $3,500.

Out-of-Pocket Expenses	Hospital Indemnity Plan Benefits
$500 deductible	$1,000 admission benefit
$3,000 co-insurance	$150/day x 4 additional days = $600
Total: $3,500	**Total benefits paid to Trevor: $1,600**

100% Employee-paid

If you elect the voluntary hospital insurance plan, 100% of the cost is deducted through payroll deductions.

Monthly post-tax rates are outlined below:

Election	Monthly Cost – Low Plan	Monthly Cost – High Plan
Employee Only	$8.69	$15.95
Employee + Spouse	$15.87	$28.88
Employee + Child(ren)	$16.51	$29.72
Family	$25.63	$46.53

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. View company benefits plans, resources and documentation, 24/7 by downloading the "iNGAGED Benefits" app from the App Store or Google Play or go to https://ingagedbenefits.com/login and use company code **Leman** to login.

Accident Insurance Plan

Accident insurance offered on a voluntary basis through Mutual of Omaha provides coverage for specific injuries and treatments resulting from a covered accident. The amount of the benefit paid depends on the type of injury and care received.

How can accident insurance help?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses.

What are some common covered benefits?

- Emergency room visit
- Ambulance
- Doctor visits
- Hospital admission
- Surgery
- Medical equipment
- Outpatient therapy
- Diagnostic imaging

Covered Event/Injury	Benefit Amount
Ambulance (ground)	$200
Emergency room care	$200
Physician follow-up ($50 x 2)	$100
X-ray	$50
Concussion	$150
Broken tooth (repaired by crown)	$200
Total benefit paid by Kathy's Accident Plan	**$900**

Here's an example of how Accident Insurance can help support you

Kathy's daughter, Molly, plays soccer. During a recent game, she collided with a player, was knocked unconscious and taken to the emergency room (ER) by ambulance. The ER doctor diagnosed a concussion and a broken tooth. He ordered an x-ray scan to check for facial fractures due to swelling. Molly was released to her primary care physician for follow-up treatment and her dentist repaired her broken tooth with a crown. Thanks to Accident Insurance, Kathy will receive $900 to help pay for Molly's expenses associated with her accident.

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary accident insurance plan, 100% of the cost is deducted through payroll deductions.

Monthly post-tax rates are outlined below:

Election	Monthly Contribution
Employee Only	$4.79
Employee + Spouse	$7.39
Employee + Child(ren)	$9.24
Family	$11.91

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. View company benefits plans, resources and documentation, 24/7 by downloading the "iNGAGED Benefits" app from the App Store or Google Play or go to https://ingagedbenefits.com/login and use company code **Leman** to login.

Dental Plan

Dental Plan

A smile is the nicest thing you can wear.

Using the PPO Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists. To determine whether your dentist is in or out of your insurance network, go https://www.azblue.com/member and search the network, or call BCBSAZ to verify.

"I need specific dental care! How much does it cost?"

Plan Highlights	BCBSAZ Dental Base PPO	BCBSAZ Dental Buy-up PPO	
	In-Network Only	In-network	Out-of-network
Calendar Year Deductible			
Individual	$50	$50	
Family	$150	$150	
Annual Maximum	$1,500	$1,500	
Preventive	0% no deductible	0% no deductible	0% no deductible*
Basic Services	50% after deductible	20% after deductible	20% after deductible*
Major Services	50% after deductible	50% after deductible	50% after deductible*
Emergency Treatment / General Services (In & out of network Benefit)	50%	50%	50%
Orthodontia Services			
Adult	Not Covered	Not Covered	
Child up to age 19	Not Covered	Covered at 50%	Covered at 50%
Lifetime Maximum	N/A	$1,500	

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

*Out of network charges are reimbursed at BCBSAZ Maximum Allowable charge.

Oral Surgery, Periodontics & Endodontics Benefit highlight

- Base Plan – covered under Basic
- Buy-up Plan – covered under Major

Download the "iNGAGED Benefits" app from the App Store or Google Play or go to https://ingagedbenefits.com/login and use company code **Leman** to login.

Vision Plan

Vision Plan

Keep a clear focus on your sight.

Vision coverage is offered by Mutual of Omaha through EyeMed as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit www.mutualofomaha.com/vision or download the EyeMed Members App.

"I need specific vision care! How much does it cost?"

Plan Highlights	Mutual of Omaha Vision Base Plan $130 - 12/12/12		Mutual of Omaha Vision Buy-Up $200 - 12/12/12	
	In-network	Out of network	In-network	Out of network
Network	EyeMed		EyeMed	
Exam – Every 12 months				
	$10 copay	Up to $37	$10 copay	Up to $37
Lenses – Every 12 months				
Single	$25 copay	Up to $20	$25 copay	Up to $20
Lined Bifocal	$25 copay	Up to $36	$25 copay	Up to $36
Lined Trifocal	$25 copay	Up to $64	$25 copay	Up to $64
Lenticular	$25 copay	Up to $64	$25 copay	Up to $64
Frames – Every 12 months				
Retail Frame Allowance	Up to $130 allowance after $25 copay	Up to $45	Up to $200 allowance no copay required	Up to $79
Discount on Frame overage at participating providers	20% discount	N/A	20% discount	N/A
Contacts – Every 12 months, in lieu of lenses & frames				
Medically Necessary	Covered in full	Up to $210	Covered in full	Up to $210
Disposable	$130 allowance	Up to $104	$200 allowance	Up to $160
Laser Vision Discount	15% discount off retail price or 5% off promotional price		15% discount off retail price or 5% off promotional price	
Additional Pair of Glasses	40% discount off of additional complete pair		40% discount off of additional complete pair	

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Download the "iNGAGED Benefits" app from the App Store or Google Play or go to https://ingagedbenefits.com/login and use company code **Leman** to login.

Life & Disability

Life & Disability

Protection for your loved ones.

Basic Life and AD&D

In the event of your passing, life insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your accidental death & dismemberment (AD&D) coverage may apply.

Paid for in full by Leman Academy of Excellence, the benefits outlined below are provided by Mutual of Omaha:

- Basic Life Insurance benefit amount of $15,000.
- AD&D benefit amount of $15,000.
- Please note, benefits may reduce when you reach age 65.

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional life and AD&D coverage for you and/or your dependents is available on a voluntary basis through payroll deductions from Mutual of Omaha. Please note, benefits may reduce when you reach age 65.

For employees:	Increments of $10,000 up to 5 time's employee's salary or $500,000, whichever is less. Guarantee issue benefit is $150,000 if you enroll in the plan within 30 days of your initial eligibility.
For your spouse:	Increments of $5,000 up to $250,000 not to exceed 100% of employee amount. Guaranteed issue benefit is $30,000 if you enroll in the plan within 30 days of your initial eligibility.
For your child(ren):	Benefit of $5,000 or $10,000 benefit not to exceed 100% of employee amount.
Optional AD&D:	Coverage is available for purchase in the same amounts as optional life insurance amounts above.
New hire Guarantee Issue limit	Employee - $150,000; Spouse - $30,000; Child - $10,000
Evidence of Insurability (EOI):	EOI may be required following your benefits open enrollment period for employees and covered dependents who elect: • An initial Benefit amount or benefit increase that exceeds the guaranteed issue amount of $150,000 or the annual increase amount of $10,000. • **ANY** benefit amount more than 31 days after their initial eligibility date.

How to submit EOI?

Submit your EOI information directly online at www.mutualofomaha.com/eoi or reach out to HR to receive a copy of the form.

When completing EOI online, you'll need the following information:

- Date of Hire
- Group Number
- Current Salary
- Coverage Amounts being Requested/Elected

Required! Are your beneficiaries up to date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- You can change your beneficiary designation at any time.
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.
- To select or change your beneficiary, log in to Paylocity at Login | Paylocity

Voluntary Short & Long Term Disability

Should you experience a non-work-related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Short Term Disability (STD) **Employee Paid**	• Administered by Mutual of Omaha, STD coverage provides a benefit equal to 60% of your weekly earnings to a maximum of $1,000 per week for a period up to 24 weeks. • The plan begins paying these benefits after you have been absent from work for 14 consecutive days.
Long Term Disability (LTD) **Employee Paid**	• If your disability extends beyond 180 days, the LTD coverage through Mutual of Omaha can replace 60% of your earnings, up to maximum of $5,000 per month. • Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.

Evidence of Insurability (EOI) Guide	• **EOI may be required following your benefits open enrollment period for employees who elect Long Term Disability more than 31 days after their initial eligibility date.**
	How to submit EOI?
	Navigate to www.mutualofomaha.com/eoi.
	• **Have the following information available:**
	  • Date of Hire
	  • Group Number
	  • Current Salary
	  • Coverage Amounts being Requested/Elected

Please note, the state you reside in may provide a partial wage-replacement disability insurance plan.

Tax considerations

As an optional employee paid benefit, disability coverage is available to you on a pre-tax and/or post tax basis:

- **Pre-tax:** By paying for your disability coverage on a pre-tax basis, you will pay income taxes on any STD and/or LTD benefits you receive. In effect, you are reducing your taxable income and will not have income taxes withheld on the portion of your income used to pay your disability insurance.
- **After-tax:** If you pay your disability coverage on an after-tax basis, you will not have to pay income taxes on any STD and/or LTD benefits you receive.

Please note: Consult your tax advisor for additional taxation information or advice.

Value Added Benefit included with Mutual of Omaha

Employee Assistance Program – Available to Employees who have enrolled in the LTD coverage

- Provides members and their families personal and confidential support 24/7 - unlimited phone access
- Up to 3 telephonic counseling sessions
- One legal consultation for 30 minutes by phone or in person
- Inclusive financial platform through Enrich
- Call EAP at 1-800-316-2796

Mutual of Omaha Value-Added Benefits included with Basic Life

A Guide to your life insurance benefits

Will Preparation Services

Creating a will may help give you more control over future events and helps your family follow your wishes. Your life insurance plan includes online will preparation services to help you:

Prepare your will today at www.willprepservices.com – Use code MUTUALWILLS to register

- Create and prepare a will – registration is required
- Locate nearby attorneys, search legal forms, find helpful articles by legal experts and more.
- Access financial planning help and cost calculators.

Identity Theft Assistance

If your identity is compromised, the most important thing to do is respond quickly. We will provide you with educational resources regarding the steps to take to recover your identity from credit card and check fraud. We will also provide you with a contact list for financial institutions, credit bureaus and check companies.

Access ID Theft Assistance Services by calling AXA Assistance toll-free at 1-800-856-9947

Travel Assistance

Enjoy Your Trip – We'll Be There If You Need Us – 24/7

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home.

Pre-trip Assistance

Minimize travel hassles by calling us pre-departure for:

- Information regarding passport, visa or other required documentation for foreign travel
- Travel, health advisories and inoculation requirements for foreign countries
- Domestic and international weather forecasts
- Daily foreign currency exchange rates
- Consulate and embassy locations

Emergency Travel Support Services

- Telephonic translation and interpreter services – 24/7 access to telephone translation services
- Locating legal services – referrals for local attorney or consular offices and help maintain business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- Baggage – assistance with lost, stolen or delayed baggage while traveling on a common carrier
- Emergency payment and cash – assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- Emergency messages – assistance with recording and retrieving messages between you, your family and/or business associates at any time
- Document replacement – coordination of credit card, airline ticket or other documentation replacement
- Vehicle return – if evacuation or repatriation is necessary, return your unattended vehicle to the car rental company

Download the "iNGAGED Benefits" app from the App Store or Google Play or go to https://ingagedbenefits.com/login and use company code **Leman** to login.

Retirement

Retirement

Make retirement a reality, not a wish.

Your 401(k) Plan Option

Administered by Empower, the 401(k) plan allows you to plan for your future by investing a portion of each paycheck. Once you become eligible, you may elect to have a percentage of your paycheck withheld and invested in your 401(k) account, subject to federal law and plan guidelines. See Human Resources to confirm eligibility and enrollment dates. Automatically enrolled at 6% the 1st of the month following 90 days of employment.

Enrollment & Account Access

If you have any questions or for more information, please visit https://participant.empower-retirement.com/participant/#/login or contact your benefit administrator. We hope you'll take full advantage of this important benefit!

Empowers interactive retirement plan website https://participant.empower-retirement.com/participant/#/login allows you to access your account online 24 hours a day, 7 days a week. You can also reach out directly at 855-756-4738.

Additional 401(k) Information

Contribution Limits: For 2025, the IRS annual contribution limits are $23,500 for everyone under age 50 or $31,000 for anyone that is age 50 or over prior to December 31, 2025. If you have multiple employers during the year, all your contributions are combined. Restrictions may apply to these limits based on plan documents and annual testing requirements. The major notable change this year is the Super Catch-Up for those aged 60 to 63. For those in this age range, the Super Catch-Up allows for an increased catch-up contribution of 150% of the Catch-Up Limit. For 2025 the Super Catch-up limit is $11,250 vs $7,500 for all others. Please note, the Super Catch-Up is NOT available in the year one reaches age 64.

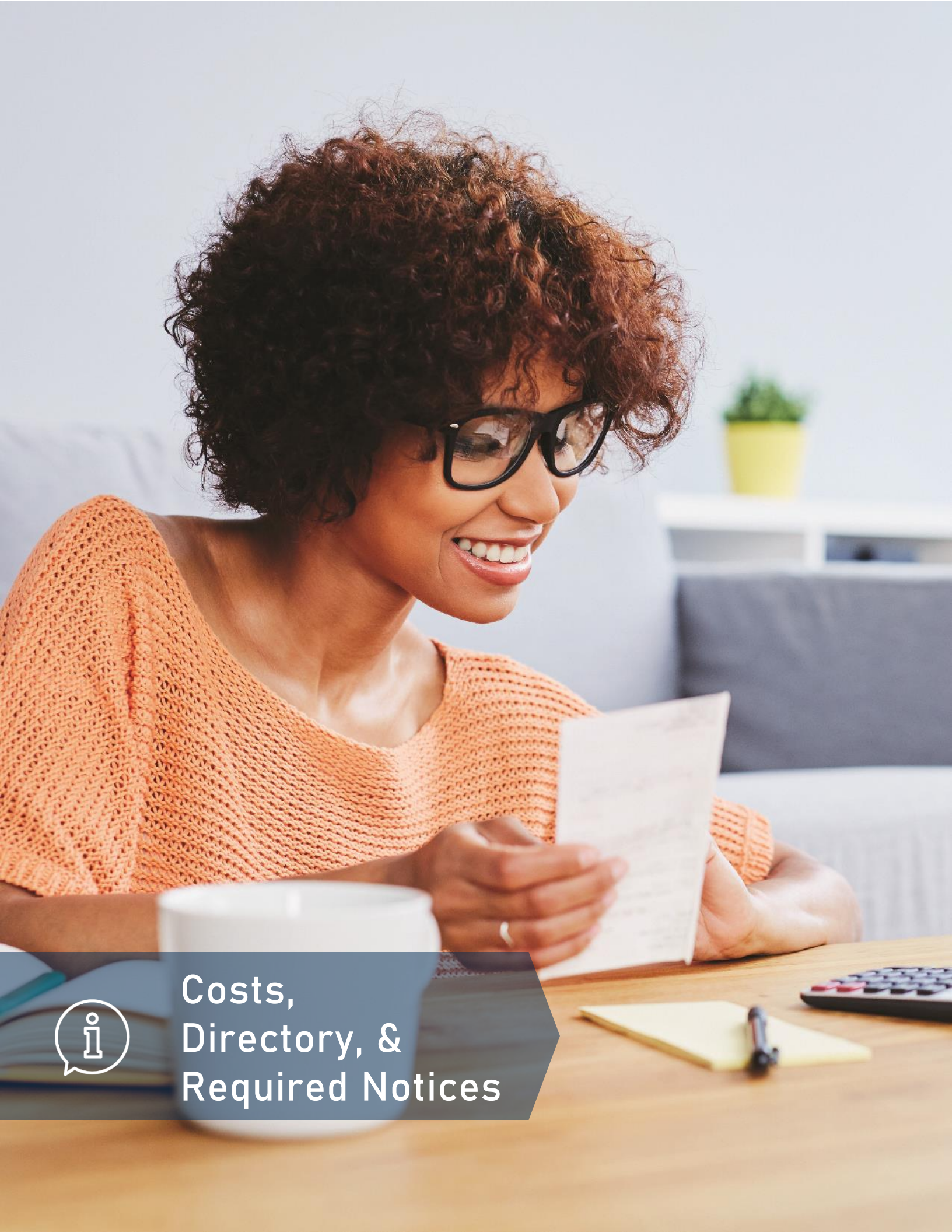
Contribution Changes: Check with Human Resources for frequency and process for changing your contributions. You may also stop your contribution entirely at any time. Requests to change or stop your contributions must be made through the provider website or in writing to Human Resources.

Employer Contributions: Check with Human Resources for current status of any employer contributions to the plan.

Loans & Hardship Withdrawals: If allowed by the plan document, please see Human Resources for information and requirements for either option.

Rollover Contributions: If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your new plan. Please contact Human Resources for additional information.

Termination of Employment: Upon termination of employment from our organization, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another plan or IRA. You may also request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties which may apply to any payment other than a rollover.



Costs, Directory, & Required Notices

Medical Cost Breakdown

All of your rates in one place.

LEMAN ACADEMY of EXCELLENCE

The rates below are effective August 1, 2025 – July 31, 2026.

Coverage Level	Payroll Deduction
	Employee Biweekly
BCBSAZ – PPO $4,000 Alliance/PimaConnect	
Employee Only	$33.40
Employee and Spouse/Domestic Partner	$166.99
Employee and Child(ren)	$162.82
Employee and Family	$275.55
BCBSAZ – PPO $3,000 Alliance/PimaConnect	
Employee Only	$44.99
Employee and Spouse/Domestic Partner	$190.16
Employee and Child(ren)	$185.41
Employee and Family	$313.78
BCBSAZ – PPO $2,500 Statewide	
Employee Only	$62.76
Employee and Spouse/Domestic Partner	$225.71
Employee and Child(ren)	$220.07
Employee and Family	$372.43
BCBSAZ – HSA $3,300 Statewide	
Employee Only	$47.21
Employee and Spouse/Domestic Partner	$194.60
Employee and Child(ren)	$189.73
Employee and Family	$321.10
BCBSAZ – PPO $1,000 Statewide	
Employee Only	$99.58
Employee and Spouse/Domestic Partner	$299.36
Employee and Child(ren)	$291.87
Employee and Family	$493.95

Dental & Vision Cost Breakdown

All of your rates in one place.

LEMAN ACADEMY of EXCELLENCE

The rates below are effective August 1, 2025 – July 31, 2026.

Coverage Level	Payroll Deduction
	Employee Biweekly
BCBSAZ - Dental Base PPO Plan	
Employee Only	$2.15
Employee and Spouse/Domestic Partner	$10.76
Employee and Child(ren)	$10.86
Employee and Family	$16.74
BCBSAZ - Dental Buy-up PPO Plan	
Employee Only	$5.10
Employee and Spouse/Domestic Partner	$16.66
Employee and Child(ren)	$21.43
Employee and Family	$31.70
Mutual of Omaha - Vision PPO Base Plan - $130	
Employee Only	$3.00
Employee and Spouse/Domestic Partner	$6.22
Employee and Child(ren)	$7.26
Employee and Family	$10.41
Mutual of Omaha - Vision PPO Buy-up Plan $200	
Employee Only	$3.94
Employee and Spouse/Domestic Partner	$8.63
Employee and Child(ren)	$10.02
Employee and Family	$14.60

Directory & Resources

Below, please find important contact information and resources for Leman Academy of Excellence.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources		520.499.1474	hr@lemanacademy.org
Online Enrollment Vendor: • Paylocity			https://access.paylocity.com
Medical Coverage			
Blue Cross Blue Shield of Arizona	101114	800.232.2345	www.AZBlue.com
Health Savings Account			
Optum Bank		877.620.6194	www.optumbank.com
Supplemental Health			
Mutual of Omaha • Accident, Hospital & Critical Illness	G000CQ84	800.775.8805	www.mutualofomaha.com/forms submitgrpacc@mutualofomaha.com submitgrpci@mutualofomaha.com submitgrphi@mutualofomaha.com
Dental Coverage			
Blue Cross Blue Shield of Arizona	101114	888.271.7806	www.AZBlue.com
Vision Coverage			
Mutual of Omaha	G000CQ84	833.279.4358	www.mutualofomaha.com
Life, AD&D and Disability			
Mutual of Omaha • Life & AD&D • Short Term & Long-Term Disability • Evidence of Insurability EOI	G000CQ84	Life & Disability 800.775.8805	www.mutualofomaha.com www.mutualofomaha.com/forms https://www3.mutualofomaha.com/eoi/#/home
Employee Assistance Program			
Mutual of Omaha		800.316.2796	https://www.mutualofomaha.com/eap/
401(k) Retirement Plan Adviser			
Empower	843306	855.756.4738	https://participant.empower-retirement.com/participant/#/login
Benefit and Claims Advocacy Assistance			
Health Advocate		866.695.8622	www.healthadvocate.com/members
Benefits Broker / Claims Questions			
Marsh & McLennan Insurance Agency LLC Claims Advocate - Shan O'Connor		602.385.7069	Shan.o'connor@marshmma.com

Guidelines/Evidence of Coverage

The benefit summaries listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Leman Academy of Excellence Health and Welfare Benefits Annual Notice Packet

For the 2025 Plan year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights
- ☐ Fixed Indemnity Policy Notice

Should you have any questions regarding the content of the notices, please contact Human Resources.

Medicare Part D
Creditable Coverage Notice

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Leman Academy of Excellence has determined that the prescription drug coverage offered by the Leman Academy BCBSAZ PPO Plans* are, 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.**

*BCSBAZ PPO $4,000 Alliance/PimaConnect, BCBSAZ PPO $3,000 Alliance/PimaConnect, BCBSAZ PPO $2,500 Statewide, BCSBAZ PPO $1,000 Statewide, BCBSAZ HDHP $3,300

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan while enrolled in Leman Academy of Excellence coverage as an active employee, please note that your Leman Academy of Excellence coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Leman Academy of Excellence coverage as a former employee.

You may also choose to drop your Leman Academy of Excellence coverage. If you do decide to join a Medicare drug plan and drop your current Leman Academy of Excellence coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Leman Academy of Excellence and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 8/1/2025
Name of Entity/Sender: Leman Academy of Excellence
Contact-Position/Office: Alexa Goldkuhl / Director of Human Resources
Address: 3300 E Sunrise Dr., Ste. 150 Tucson, AZ 85718
Phone Number: 520-499-1839

HIPAA Special Enrollment Rights Notice

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

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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Human Resources at 520-499-1474 or hr@lemanacademy.org.

HIPAA Notice of Privacy Practices

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.

Leman Academy of Excellence sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Leman Academy of Excellence, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or

created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Leman Academy of Excellence, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Leman Academy of Excellence HIPAA Privacy Officer:

Leman Academy of Excellence
Attention: HIPAA Privacy Officer
3300 E. Sunrise Dr., Ste. 150
Tucson, AZ 85718
520-499-1839

Effective Date

This Notice as revised is effective August 1, 2025.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. 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 visitinghttps://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html .

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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, 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	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: masspremiumassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program| Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), 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?

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, contact your plan administrator at 520-499-1474.

Newborns' and Mothers' Health Protection Act (NMHPA) 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 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).

Model General Notice of
COBRA Continuation Coverage Rights

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice t Human Resources.

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, Medicare, 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, 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/agencies/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**.

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

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
Leman Academy of Excellence
Alexa Goldkuhl / Director of Human Resources
3300 E. Sunrise Dr., Ste. 150
Tucson, AZ 85718
520-499-1839

Fixed Indemnity Policy Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Prepared by: Lovitt & Touché, A Marsh & McLennan Insurance Agency LLC
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