Greater Atlanta Christian School

Enroll July 27 to August 9

2020-21 Open Enrollment Guide

Benefits for your health and financial security

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Greater Atlanta Christian School (GACS) takes pride in offering a benefit program that provides flexibility for the diverse and changing needs of our employees. GACS offers employees and their family members a full range of benefits. You choose the options that best meets your needs. This brochure provides a summary of your benefit options and is designed to help you make choices and enroll for coverage. If you would like more information about any of the benefits described here, please contact your Human Resources Office. Also, note that the plan descriptions contained herein are a summary and the respective provider's Summary Plan Description will take precedence.

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Resources and Contacts

Below is a list of insurance carrier contacts should you require assistance with your benefit questions following open enrollment.

Accident, Hospital, and Critical Illness – UNUM	
UNUM	(800) 635-5597 / www.unum.com
Claims Advocacy	
Benefit Resource Center	(855) 874-0835 / BRCSouth@usi.com
Dental – Guardian	
Guardian	(800) 541-7846 / www.guardiananytime.com
Disability *(Short & Long-Term)* – Lincoln Financial Group	
Lincoln Financial Group	(800) 423-2765 (reference ID of GTCS) / www.lincoln4benefits.com
Employee Assistance Program (EAP) – Lincoln Financial Group	
Lincoln Financial Group	(855) 327-4463 / www.GuidanceResources.com; Web ID = Lincoln
Flexible Spending Account – PayFlex *(Aetna third-party provider)*	
PayFlex	(888) 678-8242 / www.payflex.com
HSA Contribution Fund – PayFlex *(Aetna third-party provider)*	
PayFlex	(888) 678-8242 / www.payflex.com
Identity Theft – InfoArmor	
InfoArmor	(800) 789-2720 / www.myprivacyarmor.com
Legal Plan – MetLife	
MetLife	(800) 821-6400 / www.legalplans.com
Life Insurance – Lincoln Financial Group	
Lincoln Financial Group	(800) 423-2765 (reference ID of GTCS) / www.lincoln4benefits.com
Medical and Prescription Drugs – Aetna	
Aetna Website	(888) 266-5519 / www.aetna.com
Nurse Line	
Member Services	800) 556-1555
Retirement Plan – Principal Financial Group	
Principal Financial Group	800) 547-7754 / www.principal.com
Student Loan/College Savings – BenefitEd	
BenefitEd	support@youbenefited.com / 844.358.5707
Teladoc	
Teladoc	(855) 835-2362 / www.teladoc.com/aetna
Vision – Eyemed *(Aetna third-party provider)*	
Aetna	(877) 973-3238 / www.aetnavision.com

NOTE: If you are unable to resolve your issues or questions with the insurance carriers, please contact your Human Resources Office at AskHR@greateratlantachristian.org or (770) 243-2214, (770) 243-2238, (770) 243-2239, or (770) 243-2241.

Ready to Take Action… for a Healthy 2020-21

It's time to enroll for your GACS benefits!

You may actively enroll between July 27 and August 9, 2020.
Before you do, understand what's changing, key terms and resources to help your decision-making, and the actions you need to take during Open Enrollment.

Your Open Enrollment Resources

- **Read this 2020-21 Benefit Guide**. You'll find detailed information about your benefit options and how to enroll. Aetna's Summary of Benefits and Coverage for both medical plans are provided to you three ways: (1) posted in the benefit election site, (2) posted under "Benefits" in your Paylocity self-service portal, and (3) in MyGAC under "Benefits" in HR.

- **View an Open Enrollment webinar.** This forum will provide more in-depth information about your benefit options. Visit Paylocity at **https://login.paylocity.com** under "Benefits" to view the recorded webinar.

- **Contact your HR office or the carriers.** Your Human Resources team and the carriers are available to answer any questions you may have.

- **Review and, if needed, add or update your demographic and dependent information.** Login to Paylocity at **https://login.paylocity.com** to access the "Hi, {Your Name}" section. Click on both the Demographic and Dependent sections to review and, if needed, add or update your information. Make sure all of your dependent (spouse and children) information is reflected.

- **Log onto Paylocity from Monday, July 27 through Sunday, August 9.** You must make your 2020-21 elections no later than 11:59 p.m. Eastern Standard Time, on August 9. If you don't, you will not have any benefits until the following plan year. See page 6 for detailed instructions on how to enroll.

Important Things to Do

Open Enrollment is your once-a-year opportunity to review your GACS benefits, assess your needs and make changes for the following year. You must act before the August 9 deadline to do the following:

1. Reaffirm Attestations for 2020-21

- If you attest that you and your participating spouse will participate in the GACS Wellness Program, you will not incur a non-participation monthly deduction of $125.. If either of you do not complete the wellness requirements by June 1, 2021, you will be charged $1,500 ($125 x 12 months). See page 13 for details.

- If your spouse does not work at GACS but is eligible for other employer-provided medical coverage and you elect to cover your spouse under your GACS medical option, you will incur an additional charge for that coverage.

    - The surcharge will be $50 per month. To avoid this surcharge, your spouse must elect coverage under his or her employer's medical plan.

2. Review Your Out-of-Pocket Healthcare Expenses. Review your out-of-pocket medical, prescription, dental and vision expenses for the past year. List any potential healthcare services you foresee for the upcoming year. Between your last year's expenses and your anticipated next year expenses estimate your out-of-pocket healthcare expenses for next year. Use this amount to determine any contribution to an HSA fund (if you elect one of the HSA medical plans) or Flexible Spending Account (FSA).

3. Check Your Coverage Levels and Beneficiaries for Life Benefits. This is a good time to make sure you don't need to make any changes to your coverage levels or beneficiaries.

Enrollment Information

Who May Enroll

All active, full-time employees who work a minimum of both 1,000 hours annually and 30 hours per week may participate in GACS' benefits program. Your eligible dependents may also participate. Eligible dependents include:

- Legal spouse
- Children (natural, adopted, and step children) from birth up to age 26, married or unmarried. Note that you must be the legal guardian and:
  - Primary residence must be with you or,
  - You must provide court-ordered medical support or,
  - Adult children age 18 to 26.
- Mentally or physically disabled child over the age of 26, if they were defined as disabled before age 24, who is dependent on support from you and whose primary residence is with you.

Documentation Required to Add Dependents

To add dependents up to age 26, a copy of a birth or adoption certificate is required. To add a spouse, a copy of the marriage certificate is required. This documentation must be submitted to the Human Resources Office.

When You Can Enroll

- As a new hire within 30 days of date of hire
- **During annual Open Enrollment, which for 2020-21 is July 27 through August 9, 2020**
- Within 30 days of a qualified change in family status as defined by the IRS – see "Changes to Enrollment"(page 7)

How to Enroll

The following steps will guide you through the Open Enrollment process:

1. Carefully review the plan information in the **2020-21 Open Enrollment Guide** and all other plan materials in your enrollment packet. The insurance carrier's websites also provide important information and tools that can help you make enrollment decisions.
2. Consider the needs of any dependents you may have. If you are married and your spouse is eligible for benefits through his/her employer, review the coverage currently offered through your spouse's employer to compare to GACS' coverage.
3. Enrollment is completed on the Paylocity website **(https://login.paylocity.com)**. Selecting your benefits is fast, easy, and convenient with the online enrollment system. You will be able to make decisions and changes online and get immediate confirmation of your selections.
4. Be sure to use as your web browser either Chrome or Firefox. Do not use an iPad or mobile phone. Remember the company id is **N2090**.
5. Once you are logged in, you first need to verify your information. To do so:
   - Expand the area titled "Hi, Your Name" and then click on "More"
   - Click on "Demographics" and "Dependents" to verify and/or update both your demographic and dependents (spouse and children) information
   - Click on "HR & Payroll" on top left and then click on "Enterprise Benefits"
   - Click on "Enroll Now" and follow the steps to elect or waive each benefit option
   - Once you finish making your elections, check "I agree, and I'm finished with my enrollment"
   - Click on "Save My Enrollment"
6. If needed, you may re-access the enrollment site and make changes to your elections as often as you wish during the Open Enrollment period.

"Ask Emma" is a decision-making benefit comparison tool within the enrollment site. It will provide a plan comparison of the medical and dental plan options based on your anticipated costs to help you select the plan that is best for you and your family.

Enrollment Information

Paying for Your Coverage

The Basic Life, AD&D (accidental death and dismemberment), Long-Term Disability, Employee Assistance Program (EAP) and Will Service benefits are provided at no cost to you and are paid entirely by GACS. You and GACS share in the cost of the Medical benefits you elect. The Voluntary benefits (accident, critical illness, dental, disability, hospital, identity theft, legal, life, and vision) you elect will be paid by you at discounted group rates. Your Medical, Dental, and Vision premiums are deducted before taxes are withheld which saves you tax dollars. Paying for benefits before-tax means that your share of the costs is deducted before taxes are determined, resulting in more take-home pay for you. As a result, the IRS requires that your elections remain in effect for the entire year. You cannot drop or change coverage unless you experience a qualifying status change.

Changes to Enrollment

Our annual benefit plans are effective September 1 through August 31. There is an annual open enrollment period each year, during which you can make new benefit elections for the following September 1 effective date. Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualified change in family status as defined by the IRS or if you qualify for a "special enrollment." However, **any changes you make must be consistent with the change in status and you must make the changes within 30 days from the date the event occurs (marriage, birth, etc.) unless otherwise noted below**. If you qualify for a mid-year benefit change, you may be required to submit proof of the change.

A qualified change in family status includes:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, and death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status that affects benefit eligibility, including the start or termination of employment by you, your spouse, or your dependent child.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in place of residence, including a change that affects the accessibility of network providers.
- Change in your health coverage or spouse's coverage attributable to your spouse's employment.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA) including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act. Under provisions of the Act, employees have 60 days after the following events to request enrollment:
    - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
    - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Note:
Remember that coverage for a new spouse or newborn child is not automatic. If you experience a change in family status, you have 30 days to update your coverage. Please contact the Human Resources Office immediately to provide the appropriate documentation and complete the online enrollment. If you do not update your coverage within 30 days from the family status change, you must wait until the next annual open enrollment period to update your coverage.

What's New for 2020-21

- **NEW MEDICAL PLAN OPTION**: Aetna Select Plan with $2,000 Individual Deductible
  - This new medical plan is based on an Accountable Care Organization (ACO) model which includes doctors and hospitals within Emory Healthcare Network and Northside Hospital Systems.
  - To maximize success, health care is delivered by your healthcare team, led by your Primary Care Physician (PCP). You don't have to choose a PCP but it is recommended that you establish a relationship with a physician who will know you and your medical history.
  - Please visit aetna.com and select "Find a doctor" and confirm that your healthcare provider is in the Aetna Whole Health network.

  Note: This medical plan option is only available to employees who live in the **Cherokee, Clayton, Cobb, DeKalb, Forsyth, Fulton, Gwinnett, Henry and Rockdale** counties.

- **NEW Aetna Member Customer Services Number**
  - Please note the new Aetna Member Customer Services Number: (888) 266-5519.

- **The Aetna provider network for the Saver and Classic plans is changing to the Choice POS II plan, which is a more expanded network of providers.**

- **The Aetna drug list (formulary) is changing.**
  - Members affected by the transition to the Advanced Control Plan Formulary will receive communications 30-45 days before 9/1/2020.
  - To search for medications on the formulary, please click on the link to access the 2020 Advanced Control Plan Formulary: https://fm.formularynavigator.com/FBO/41/2020_Advanced_Control_Plan_Aetna_.pdf

- **The FSA Medical, Limited Purpose and HSA annual limits are increasing.**
  - Annual Limit: FSA Medical and Limited Purpose Plan: $2,750
  - Annual Limit: HSA Individual: $3,550, HSA Family: $7,100.
  - Annual HSA Catch Up Contribution is not changing: $1,000.

Please make sure to provide your new ID card to your pharmacy and your healthcare providers for any services on or after September 1, 2020.

Medical and Prescription Drugs

Understanding the Terms

To make the right choices and understand the Medical Plan Comparison Chart, it is helpful to know the following benefits terms:

Network is the group of physicians, hospitals and other providers who agree to offer services to a medical plan at lower-priced, "negotiated rates."

• **In-network**: When care is given by a participating provider, it is considered "in-network." Staying in the network for care means services will be provided at the lower negotiated fees. You will therefore pay lower out-of-pocket expenses than for out-of-network services.

• **Out-of-network**: When care is given by a provider who is outside the plan option network, it is considered "out-of-network." Services will not be provided at the network negotiated rate. Therefore, your share of the cost for out-of-network services will be much higher than for in-network services.

For health services, the following three terms are used. The most important thing to remember is how these three work together when you study the Medical Plan Comparison Chart on page 14 and 15.

Deductible	Coinsurance	Out-of-Pocket Maximum
If you have a claim, the deductible is the amount you pay each year before the medical plan begins to pay for expenses. Preventive care, covered at 100%, is not applied toward the deductible. There are two types of deductible: ▪ **Embedded Deductible:** This means the plan has individual deductibles. Each covered family member must meet the individual deductible. If two family members meet their individual deductible, then all other family members are considered to have met the deductible and then coinsurance benefits begin. ▪ **Non-Embedded Deductible:** This means there are no individual deductibles (unless you elect employee only coverage) - only a family deductible. Coinsurance benefits do not begin for any covered individual until the family deductible is met either by one member or a combination of several family members.	• Once you have met the deductible, the plan pays a percentage of the remaining covered medical services. • For example, both HSA medical plans pay 100% for many in-network services once the in-network deductible is met. You pay nothing at that point for the remainder of the benefit year.	• This feature protects you financially. The "out-of-pocket maximum" limits the amount you pay out of your own pocket each year for covered medical services. • If you seek care from in-network medical providers, when your prescription copays, deductible and coinsurance accumulate to the out-of-pocket maximum, the plan will pay 100% of covered charges for the remainder of the benefit year.

Finding a Medical Provider

Go to www.aetna.com or call 1-888-266-5519.
For the HSA Classic and Saver plan options, search under the Choice POS II Network.
For the Select plan, search under the Aetna Whole Health Network.

Medical and Prescription Drugs

Aetna Medical Plan Tools to Benefit You

Mobile App: You can use your cell phone with web access to view your health plan information — whenever you want, wherever you are. The Aetna Mobile app works with iPhone® mobile digital device, Blackberry® smartphone and Android™. Simply text **Apps** to **44040** to download. Use a different smartphone or mobile device? Instead of loading an app, just visit www.aetna.com and use the mobile web version of the site.

Payment Estimator: This free online tool lets you estimate what you will pay out of pocket for more than 650 common services and procedures. You can compare costs at up to 10 providers at once to shop for a lower-cost provider in the network. This tool factors in your deductible and coinsurance and your copay. That means you get personalized answers. Each estimate is based on your actual health insurance and benefits plan details, plus current provider charges.

DocFind: Choosing a doctor, dentist or hospital is a big decision. You want to do a little research first, right? That's why DocFind is an important tool to know. It delivers fast, accurate search results. With DocFind, you:

- Save money
- See the latest information.
- Find doctors who have met extra care and cost standards.
- Get personalized results.

Try DocFind Now: If you're an Aetna member, sign up for Aetna Navigator at **www.aetna.com**. That's how to get your personalized version of DocFind. If you're not an Aetna member, visit **www.aetna.com** and click on "Find a Doctor."

Prefer paper? If you're a member, just call the toll-free Member Services number on your member ID card for a paper directory. If you're not yet a member, call **1-888-87-AETNA (1-888-872-3862).**

Aetna Navigator Website: Aetna Navigator puts all of your plan information and cost-saving tools in one place at **www.aetna.com**. You can:

- Find doctors, pharmacies and hospitals
- Get an ID card
- Look up a claim
- Check your coverage
- Keep track of health care costs

Look what else you can do:

- Have medicines you take every day sent to your home
- Get a summary of your doctor visits, medical tests, prescriptions, and other health activities
- Print records of preventative check-ups and shots
- Look up health topics
- Complete a Health Assessment
- Get healthy living tips
- Sign up for a wellness program

Medical and Prescription Drugs

Teladoc

Teladoc gives you **24/7 access 365 days** of the year to **U.S. board certified doctors** who can treat many of your routine medical issues through phone or video consultations. **Teladoc** doctors can treat many medical conditions, including:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

Teladoc is simply a new way to access qualified doctors. All **Teladoc** doctors are:

- Practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years of experience
- U.S. board-certified and licensed in your state
- Credentialed every three years, meeting NCQA standards.

Teladoc is an added medical benefit that provides you an affordable alternative to costly urgent care, ER visits, or in some cases, physician office visits. The cost of this physician office visit (by telephone or video) is **only $45.00 for those enrolled in the Classic or Saver plan**. The PCP copay applies if you are enrolled in the Select Plan. Prior to using **Teladoc** for the first time, you will want to set up your online account so that the physician has your medical history available to aid in making an accurate diagnosis – just like the physicians you see in a physical office location. So, after the September 1st start of the benefit plan year, visit the **Teladoc** website at **Teladoc.com/Aetna**, click on "Set up account" and provide the required information. You can also call **Teladoc** at **1-855-Teladoc (835-2362)** for assistance. Once you have set up your account you will want to click on "My Medical History" to complete your information. You are not billed a fee until you actually consult with a physician when you need to.

Nurse Line

When your health question can't wait, you have a resource to turn to – a **24-Hour Nurse Line**. With one call, you will access a registered nurse to:

- Get information on a wide range of health and wellness topics.
- Get e-mails from a nurse with videos that are relevant to your question or topic.
- Make smarter health care decisions.
- Find out more about a medical test or procedure.
- Get help preparing for a doctor's visit

It's toll-free. And you can call as many times as you need to – **at no extra cost**. You can call a nurse at **1-800-556-1555.** For speech or hearing impaired, dial 711.

You can also get health information online at **www.aetna.com**, choose "Health Programs," and then 24-Hour Nurse Line." On this site, you can:

- Use the symptom checker.
- Learn about a medical test that's coming up.
- Research a new medication you're taking and more.

Medical and Prescription Drugs

Tips for Using Your Medical Plan Wisely

1. **Ask questions when in doubt.** If you are having or planning a procedure, make sure you know how the procedure will be covered and what your out-of-pocket cost will be, if any.
2. **Utilize your free preventative care benefits to stay healthy**. Preventative care benefits are covered at no charge to you. Regular preventative care can reduce the risk of disease, detect health problems early, protect you from higher costs down the road, and most importantly – save your life! Take advantage of these no cost benefits now to hopefully avoid major illnesses and costs in the future.
3. **Use generic and over the counter drugs when available**. The best way to save on prescriptions is to use generic or over-the-counter medications as opposed to brand name drugs. Generic drug companies do not have to develop a medication from scratch, so the costs are significantly less to bring the drug to the market.
4. **Use the mail-order prescription drug benefit for maintenance medications.** As an Aetna member, you will receive discounts when you purchase maintenance medications through the mail-order pharmacy. In addition, medications will be delivered to your house.
5. **Know which type medical service to use for non-emergency care**. Sometimes it's easy to know when you should go to an emergency room (ER), such as when you have severe chest pain or unstoppable bleeding. At other times, it's less clear. Where do you go when you have an ear infection, or are generally not feeling well? Telemedicine, retail health clinics, and urgent care centers may work with your schedule and give you the kind of care you need. Know when to use each for non-emergency care.

Care Option	Hours	Your Relative Cost*	Description
Teladoc 1-855-835-2362	24 hours, seven days a week, 365 days a year	$40.00	Teladoc gives you access to U.S. board certified physicians who can treat many of your routine medical issues through phone or video consultation.
Doctor's Office	Office hours vary	Usually lower out-of-pocket cost to you than urgent care	Your doctor's office is generally the best place to go for non-emergency care such as health exams, colds, flu, sore throats and minor injuries.
Retail Health Clinic	Similar to retail store hours	Usually lower out-of-pocket cost to you than urgent care	Walk-in clinics are often located in stores or pharmacies to provide convenient, low cost treatment for minor medical problems like ear infections, athlete's foot, bronchitis and some vaccinations.
Urgent Care Provider	Generally, includes evenings, weekends and holidays	Usually lower out-of-pocket cost to you than an ER visit, but be aware that some providers charge a minimum of $300	Urgent care centers can provide care when your doctor is not available and you don't have a true emergency, but need immediate care. For example, they can treat sprained ankles, fevers, and minor cuts and injuries.
Emergency Room (ER)	24 hours, seven days a week, 365 days a year	Higher out-of-pocket cost to you	*For medical emergencies, call 911 or your local emergency services first.* Emergency rooms treat emergency medical conditions such as, difficulty breathing, any type of severe pain, loss of consciousness, broken bone, severe allergic reactions, or bleeding that doesn't stop.
24/7 Nurse Line** 1-800-556-1555	24 hours, seven days a week, 365 days a year	No cost	The 24/7 Nurse Line can help you decide if you should call your doctor, go to the ER, or treat the problem yourself. They can answer many of your health-related questions and help you understand your condition.

*The relative costs described here are for network providers. Your costs for out-of-network providers may be significantly higher.
**24/7 Nurse Line is not a substitute for the sound medical advice of your doctor. If you have questions or concerns regarding your health, you should discuss them with your doctor.

Medical and Prescription Drugs

GACS Wellness Program

The GACS Wellness Program is intended to help employees, and their spouse, improve their health and well-being through preventative care. Any employee (and their covered spouse) who elects to participate in one of the medical plan options is eligible to participate in the GACS Wellness Program. Participation is voluntary. However, any eligible employee (and covered spouse) who elects to not participate in the GACS Wellness Program will incur a $125 non-participation fee from his/her monthly paycheck for the entire plan year. The GACS Wellness Program is comprised of two parts as follows:

1. **Annual Physical**: An annual physical must be completed within the 12-month period preceding June 1, 2021. An annual physical is paid 100% by the Aetna medical plan, provided there has only been one in the preceding twelve months and the physician's billing office has correctly coded the office visit. You must have your primary care physician with whom you had the annual physical complete an "Annual Physical Certification" form. This form must be faxed directly from the physician's office to AskHR@greateratlantachristian.org on or before June 1, 2021. Since it occasionally takes several weeks or even months to obtain an annual physical appointment, it is recommended you contact your physician as soon as possible to schedule your appointment.
2. **Health Risk Assessment (HRA)**: An online Health Risk Assessment (HRA) must be completed through your member account within Aetna's website on or before June 1, 2021.

Failure to Complete Wellness Requirement

If either you or your participating spouse elect to participate in the GACS Wellness Program but fail to complete any of the above two steps by the noted deadlines above, it will result in $1,500 ($125 per month for the 12-month plan year) being deducted from your pay within the June through August 2021 pay periods.

Additional Employer HSA Contribution

In addition, for those employees who participate in either the HSA Classic or HSA Saver medical plans, if you (and your spouse, if covered in the medical plan) each voluntarily complete one online Aetna Journey Health program by June 1, 2021, then GACS will contribute $300 to your HSA (Health Savings Account) fund upon completion. Note that each health program takes an average of four to six weeks to complete. The reason is they are intended to improve a health behavior which research shows is ideally done over a period of time.

Steps to Access Aetna's Online HRA and Health Program (Journey)

1. Log in to Aetna at **www.aetna.com**
2. Click on "Health Records" at the top or click on "Health Assessment" on the left menu
3. Click on "Take a Health Assessment"
4. On this landing page, you will be able to complete both the Health Risk Assessment and the online Health Program by:
    a. For the Health Risk Assessment, click on "Launch" in that section
    b. For the online Health Program, click on "Launch My Program" in that section

Additional $50.00 Monetary Reward for Completion of Aetna's HRA and Health Program

For completion of your Aetna HRA and Health Program, Aetna rewards you (the employee) with a $50.00 gift card through their rewards website (notification via an email to you). You may check the status of your reward eligibility by:

- Logging on to Aetna at www.aetna.com
- Click on "Incentives" on left-side menu

You may redeem your $50.00 incentive by logging in to **www.aetnarewards.com**.

Medical and Prescription Drugs

Medical Plan Options Overview

You may choose to enroll in one of three medical plan options provided by Aetna. The primary difference between the below options is how you pay for your health care expenses.

HSA Classic Plan *("pay up-front"): Aetna POS Plan*

• **Higher** monthly premiums, but **lower** deductibles and out-of-pocket maximums.
• The family deductible applies to all members (except EE only coverage). Once any combination of covered family members reaches the annual deductible, the plan starts paying coinsurance for all family members.

HSA Saver Plan *("pay as you go"): Aetna POS Plan*

• **Lower** monthly premiums, but **higher** deductibles and out-of-pocket maximums.
• Each covered family member must meet their individual deductible before the medical plan starts paying coinsurance; however, if two covered family members meet their individual deductibles then all covered family members are considered to have met their individual deductible.

Select Plan (*Aetna Whole Health Plan*)

• **Lower** deductibles and copays for office visits and prescription medications.
• Provider network is limited to Emory Healthcare Network & Northside Hospital System. Includes 900+ primary care doctors, 3,500+ specialists, 14 hospitals, and 500+ outpatient service locations.
• This plan is **NOT** available to employees residing outside of the Emory and Northside service area; you therefore must reside in the **Cherokee, Clayton, Cobb, DeKalb, Forsyth, Fulton, Gwinnett, Henry and Rockdale** counties to be eligible to select this plan.

Health Savings Account (HSA)

The HSA Plans are a high-deductible medical plan paired with an HSA fund account. A Health Savings Account gives you the opportunity to save pre-tax dollars in a bank account to pay for qualified medical expenses now or in the future. The account belongs to you, even if you change employer. Your HSA bank account is maintained by Citibank. Since there is no use it or lose it rule, the unused funds roll over at the end of each benefit year. You are responsible for making sure that you do not contribute more than is permitted to your HSA account under federal tax law (see page 15). The employer's and employee's contributions count toward the total allowable contribution limits. The money deposited can be invested and grows tax-free. Funds are available as they are deposited in the account. You can change your HSA contributions at any point, which gives you flexibility in saving for your healthcare needs.

GACS is providing a matching contribution of $300 to the employee's HSA fund (should an employee not participate for the full benefit year, then the contribution will be pro-rated). If enrolled in an HSA plan, you may participate in a "Limited Purpose FSA" plan which allows pre-tax contributions to reimburse your eligible out-of-pocket dental or vision expenses.

Are you eligible for an HSA?
To enroll in an HSA, you must be enrolled in a qualified high-deductible health plan. In addition, you cannot have:
• Other health coverage that pays for out-of-pocket health care expenses before you meet your plan deductible
• A general-purpose health care flexible spending account or health reimbursement arrangement in the same year (and neither can your spouse)
• Medicare or TRICARE
• Veterans Affairs medical benefits that have been used in the prior three months — except in cases where the hospital care or medical services were for a serviceconnected disability
• Someone claim you as a dependent on their tax return

Medical and Prescription Drug Plans

Side-by-Side Comparison	Plan 1 - HSA Classic POS In-Network~	Plan 2 - HSA Saver POS In-Network~	Plan 3 – Select ACO In-Network Only
Network	**Choice POS II**	**Choice POS II**	**GA Aetna Whole Health**
Annual Deductible	***Non-Embedded***	***Embedded***	***Embedded***
Individual	$3,275	$5,000	$2,000
Family	$6,550	$10,000	$4,000
Coinsurance	100% Plan pays^	100% Plan pays^	80% Plan pays^
Maximum Out-of-Pocket*			
Individual	$3,275	$6,550	$5,000
Family	$6,550	$13,100	$10,000
Physician Office Visit			
Primary Care	100% Plan pays^	100% Plan pays^	$30 Copay
Specialty Care	100% Plan pays^	100% Plan pays^	$60 Copay
Preventive Care (No Deductible for In-Network Services)			
Adult Periodic Exams	100% Plan pays	100% Plan pays	100% Plan pays
Well-Child Care	100% Plan pays	100% Plan pays	100% Plan pays
Diagnostic Services			
X-ray and Lab Tests	100% Plan pays^	100% Plan pays^	80% Plan pays^
Complex Radiology	100% Plan pays^	100% Plan pays^	80% Plan pays^
Urgent Care Facility	100% Plan pays^	100% Plan pays^	80% Plan pays^
Emergency Room Facility Charges*	100% Plan pays^	100% Plan pays^	80% Plan pays^
Inpatient Facility Charges	100% Plan pays^	100% Plan pays^	80% Plan pays^
Outpatient Facility, Surgical Charges	100% Plan pays^	100% Plan pays^	80% Plan pays^
Mental Health / Substance Abuse			
Inpatient / Residential Treatment	100% Plan pays^	100% Plan pays^	80% Plan pays^
Office Visit	100% Plan pays^	100% Plan pays^	$60 Copay
Other Services			
Chiropractic (Limited to 20 visits/year)	100% Plan pays^	100% Plan pays^	$60 Copay
Prescription Drug Formulary	Advanced Control Plan https://fm.formularynavigator.com/FBO/41/2020_Advanced_Control_Plan_Aetna_.pdf		
Retail / Mail Pharmacy (30 / 90 Day Supply)			
Generic (Tier 1)	$0 copay^	$10 / $25 copay^	$20 / $50 copay
Preferred (Tier 2)	$0 copay^	$30 / $75 copay^	$45 / $112.50 copay
Non-Preferred (Tier 3)	$0 copay^	$60 / $150 copay^	$90 / $225 copay
Preferred Specialty (Tier 4) (30-day supply limit)	Specialty drugs: Tier 2 or 3	20% your cost^ - up to $250	$250 Copay
Non-Preferred Specialty (Tier 5) (30-day supply limit)	Specialty drugs: Tier 2 or 3	30% your cost^ - up to $500	$500 Copay

^ After deductible

~ Out-of-network coverage is available at higher member cost-share.

Medical and Prescription Drugs

HSA Plan FAQs

What are the contribution (employee + employer) limits *(2020)*?	$3,550/$7,100 If you will be 55 or older in 2020-21, you may contribute up to an extra $1,000.
Who may make contributions?	Employee and Employer
Are there tax savings?	Yes, in three ways: contributions go in tax-free, grow tax-free, and can be withdrawn tax-free.
Does interest accrue on contributions?	Yes
Can your contributions be invested?	Yes
Can contributions be used for non-medical expenses?	Yes, but it is subject to a 20% penalty and taxation at the regular tax rate
How are monies disbursed from the contribution fund?	Employee chooses how to utilize the funds. Funds are only available as they are deposited into the account. A PayFlex debit card may be used to access the funds or they may be transferred from the HSA account maintained by Citibank to another bank account.
How are claims substantiated?	Only the employee is required to maintain supporting documentation for IRS auditing purposes.
Can the funds be rolled over to the next benefit year?	Yes, all funds can be rolled over and used for expenses in future benefit plan years.
What are the portability and forfeiture guidelines?	The funds are portable and belong to the employee. It can be kept if the employee leaves employment and the remaining funds can be used even if the employee is no longer enrolled in a qualifying high-deductible healthcare plan. However, further contributions to the account can only be done if the employee is enrolled in a qualified high-deductible healthcare plan.

Coverage Level	Medical Plan Premium Rates*		
	HSA Classic	HSA Saver	Select **(see footnote)
Employee Only	$217.69	$85.02	$192.68
Employee + Spouse	$448.49	$314.47	$441.85
Employee + Child(ren)	$433.68	$304.46	$427.20
Family	$681.02	$489.94	$670.95

*A working spouse surcharge in the amount of $50.00 will be added to the above premium rates if your working (non-GACS) spouse is eligible for coverage through their employer but elects coverage in one of the GACS medical plan options. This provision does not apply if both spouses are GAC employees.

** This medical plan is only available to eligible employees who reside in the **Cherokee, Clayton, Cobb, DeKalb, Forsyth, Fulton, Gwinnett, Henry and Rockdale** counties.

Dental

A visit to your dentist can help you keep great smile and prevent many health issues. But dental care can be costly and you can be faced with unforeseen expenses. Did you know that a crown can cost as must as $1,400? Guardian dental insurance will help you pay for it.

With access to one of the largest network of dental providers in the country who agreed to charge negotiated fees for their services of up to 30% less than average charges in the same area, you will benefit from lower out-of-pocket costs, quality care from a screened and reviewed dentist, no claim forms to file, and excellent customer service. You may choose from one of two dental plan options from Guardian:

1. **Standard Plan**
2. **Deluxe Plan**

The Dental Plans are passive (PPO) plans which means the benefits are the same in or out of network. But, if you use an in-network dentist, you will not have any balance billing for charges over reasonable and customary. **Note that, although you enroll in the Dental Plan during Open Enrollment, its plan year is based on the calendar year.** There will be no change to either of the dental plans or their associated premiums for 2020-21.

Note:

We strongly recommend you ask your dentist for a predetermination if total charges are expected to exceed $250.

Predetermination enables you and your dentist to know in advance what the payment will be for any service that may be in question.

Dental

Dental Plan Features		Standard		Deluxe	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible *(Based on the calendar year)*	**Individual**	$50	$50	$50	$50
	Family	$150	$150	$150	$150
Annual Maximum *(based on the calendar year)*		$1,000	$1,000	$2,000	$2,000
Preventative Care • **Cleanings** *(twice / 12 months)* • **Oral exams** *(twice / 12 months)* • **X-rays** *(full-mouth once / 60 months)* • **Space maintainers** • **Sealants** *(up to age 16; once / 36 months)* • **Fluoride** *(to age 19)*		100%	100%	100%	100%
Basic • **Filings** • **Root canal** • **Perio maintenance** *(once / 3 months)* • **Simple or complex extractions**		80%	80%	80%	80%
Major • **Bridges and dentures** • **Single crowns** • **Inlays, onlays, veneers**		50%	50%	50%	50%
Orthodontia *(coverage for children up to 19)*		Not covered		50% *(Subject to a lifetime maximum of $2,000)*	
Maximum rollover • **Threshold** • **Rollover amount**		$500 $250 $1,000		$700 $350 $1,250	

Dental Plan Premium Rates		
Coverage Level	**Standard**	**Deluxe**
Employee Only	$44.96	$51.54
Employee + Spouse	$88.17	$101.51
Employee + Child(ren)	$105.67	$122.45
Family	$158.22	$183.34

Finding a Dental Provider

Go to www.guardianlife.com or call 1-800-627-4200 to find a network dental provider near you.

Vision

The Vision Plan offers you and your eligible family members the opportunity to save on vision care services and products. EyeMed is Aetna's third-party provider of the Vision Plan. There will be no change to the vision plan coverage, but the associated premiums for 2020-21 will be lower. You have two different ways to receive benefits:

- Utilize an EyeMed provider, including Lenscrafters, Target Optical, and most Pearle Vision and Sears Optical locations or,

- Go to a provider outside the network and you will receive a reimbursement for part of the cost of your vision services or products by submitting a claim form.

Vision Plan Features	In-Network	Out-of-Network
Exam *(once / 12 months)*		
• Routine comprehensive eye exam	$10 co-pay	$25 reimbursement
• Standard contact lens fit/follow-up	Member pays discounted fee of $40	Not covered
• Premium contact lens fit/follow-up	Member pays 90% of retail	Not covered
Eyeglass Lenses / Lens Options		
• Standard plastic single vision lenses	$10 copay	$20 reimbursement
• Standard plastic bifocal vision lenses	$10 copay	$40 reimbursement
• Standard plastic trifocal vision lenses	$10 copay	$65 reimbursement
• Standard plastic lenticular vision lenses	$10 copay	$65 reimbursement
• Standard progressive vision lenses	$75 copay	$40 reimbursement
• Premium progressive vision lenses	20% discount off retail minus $120 plan allowance plus $75 co-pay	Not covered
• Standard plastic scratch coating	Member pays discounted fee of $15	Not covered
• Standard anti-reflective coating	Member pays discounted fee of $45	Not covered
• Polarized and other lens add ons	Member pays 80% of retail	Not covered
Contact Lenses *(once every 12 months either 1 pair of eyeglass lenses or 1 order of contact lenses)*		
• Conventional contact lenses	$115 allowance; Additional 15% off balance over allowance	$80 reimbursement
• Disposable contact lenses	$115 allowance	$80 reimbursement
• Medically necessary contact lenses	$0 co-pay	$200 reimbursement
Frames *(once/ rolling 24 months)*		
• Any frame available, including frames for prescription sunglasses	$130 allowance; Additional 20% off balance over allowance	$65 reimbursement

Vision Plan	
Coverage Level	**Premium Rates**
Employee Only	$5.93
Employee + Spouse	$12.54
Employee + Child(ren)	$12.97
Family	$21.10

Finding a Vision Provider

Go to www.aetnavision.com or call 1-877-973-4200 to find a network vision provider near you.

Flexible Spending Accounts

A Flexible Spending Account (FSA) is a smart way to manage your share of the costs for healthcare and dependent care expenses. You save money by setting aside pre-tax dollars from your paycheck to pay for eligible expenses. For example, an individual in the 28% tax bracket would save $280 for every $1,000 they used from an FSA. You may reimburse yourself either via a PayFlex debit card at the point of service or submission of a claim form. Remember: use it or lose it! Incur all claims by August 31, 2020. It is recommended that you save your receipts in case they are needed for verification. All receipts should be itemized to reflect what product or service was purchased. Credit card receipts are not sufficient as per IRS guidelines.

You may be eligible to participate in either a General Purpose FSA or a Limited Purpose FSA to pay for eligible health expenses. And, if you need to pay for care for a dependent child or adult so that your spouse can work, a Dependent Care FSA can help you save on those costs. See the table below for details on which account is right for you and how much you may contribute in 2020-21. The FSA provider is PayFlex.

Health Account	Benefit Highlights
General Purpose FSA *(Not available to those **electing** a HSA medical plan))*	• If you enroll in the Select Plan or do not elect to participate in a medical plan option, you can set aside tax-free dollars in a General Purpose FSA to help pay for **eligible medical, dental or vision expenses** for yourself or your eligible dependents. • You can contribute up to $2,750 in 2020-21. • You can roll over up to $500 to the next plan year. • You may access your annual contribution election amount in full up front.
Limited Purpose FSA *(Only available to those **electing** a HSA medical plan)*	• If you elect to participate in one of the **HSA** medical plan options, you can set aside tax-free dollars in a Limited Purpose FSA to reimburse yourself for **eligible dental and vision** expenses for yourself or your eligible dependents. • You can contribute up to $2,750 in 2020-21. • You can roll over up to $500 to the next plan year. • You may access your annual contribution election amount in full up front.
Dependent Care FSA	• You can contribute tax-free dollars to a Dependent Care FSA to reimburse yourself for eligible day care expenses for dependent children and adults. Note: You may not use this account for healthcare expenses. • You can contribute in 2020-21 up to $5,000 or $2,500 if married and filing separately.

	• You may only access your contribution amount that has been payroll deducted.

Identity Theft Protection

Last year over 12.7 million Americans were victims of identity fraud and cleaning up the damage can be a nightmare. Do you know what you should do to protect yourself and your family? The Identity Theft Protection Plan, by InfoArmor, is a proactive and prevention plan, including a fully-managed identity restoration for state-of the-art identity protection. InfoArmor detects fraud at the source (when thieves first use your information to apply for accounts) to catch misuse sooner and minimize damages to provide complete identity monitoring. It also includes tri-bureau credit monitoring at no additional charge, an annual credit report and monthly credit scores. You will also receive access to free online tools like WalletArmor, SocialArmor, PasswordArmor, Digital Identity report, and more. **The fee is $9.95 per month for the employee or $17.95 per family per month.** Contact InfoArmor at **1-800-789-2720** or **www.myprivacyarmor.com**.

Legal Insurance

Legal insurance from MetLife's Hyatt Legal Plan offers you affordable, reliable counsel when something in life turns into a legal issue, like a dispute with a contractor, a traffic ticket or the need for estate planning. The attorneys have an average of 25 years of experience. **For just $24 per month**, you can enroll in the plan for coverage for you plus your eligible dependents and have a place to turn to for help with access to a nationwide network of attorneys for an unlimited number of legal issues who will:

- Consult with you on legal issues.
- Review or prepare documents.
- Make follow-up calls or write letters on your behalf.
- Represent you, if needed.

For more information, call MetLife at **1-800-821-6400** or **www.legalplans.com**.

Life Insurance

Supplemental life insurance with accidental death and dismemberment (AD&D) from Lincoln Financial Group offers you an opportunity to obtain additional life insurance coverage for yourself and your dependents (spouse and children) at competitive premium rates. Coverage for dependents is only available if the employee elects coverage for his or herself.

Life Insurance Plan	
Coverage Level	**Description**
Employee Only	• New hires can enroll for up to $140,000 of supplemental life insurance without having to provide proof of good health. • Increments of $10,000 • Maximum amount of $500,000 with evidence of insurability.
Spouse	• The employee must elect Employee coverage in order to elect spousal coverage. • New hires can enroll for up to $50,000 of spousal life insurance without having to provide proof of good health. • Increments of $5,000 • Maximum amount of $100,000 with evidence of insurability.
Child(ren)	• The employee must elect Employee coverage in order to elect child coverage. • Increments of $2,500

	• Maximum benefit of $10,000

For more information,
call Lincoln Financial Group at
1-800-423-2765 **www.lincoln4benefits.com**, or refer to the benefit plan documents posted under View Details in the benefit election site or under "Benefits" in your Paylocity self-service portal.

Accident Insurance

Accident Insurance pays a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events. It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles, plus . . .

- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.
- There is **Wellness Benefit** whereby every year, each family member who has Accident coverage can also receive $50 for getting a health screening test, such as:
  - ✓ Blood tests
  - ✓ Chest X-rays
  - ✓ Stress tests
  - ✓ Colonoscopies

Accident Insurance Plan	
Coverage Level	**Premium Rates**
Employee Only	$17.77
Employee + Spouse	$29.30
Employee + Child(ren)	$32.08
Family	$43.61

Hospital Insurance

Hospital Confinement Insurance pays for benefits when you're admitted to the hospital for a covered accident or illness. The money is paid directly to you – not to a hospital or care provider. It can complement your health insurance to help you pay for the costs of a hospital stay. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles. You get affordable rates when you buy this coverage at work. The benefits in this plan are compatible with a Health Savings Account (HSA). This plan has a pre-existing condition limitation (For more information, refer to plan documents posted in the benefit election site or on your Paylocity self-service portal under the Benefits section). The plan includes:

- $1,000 for each covered hospital admission - once per year
- $100 for each day of your covered hospital stay, up to 15 days - once per year
- $200 for each day you spend in intensive care, up to 15 days - once per year

Hospital Confinement Insurance Plan Premium Rates*			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Spouse and Child(ren)**
$22.22	$42.53	$30.20	$50.51

*For illustrative purposes only. Actual cost may vary. Family coverage options assume employee and spouse are in the same age band.

Critical Illness Insurance

Critical Insurance, if you're diagnosed with an illness that is covered by this insurance, you'll receive a benefit payment in one lump sum. You can use the money however you want. The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles. You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions. If you have a different condition later, you can receive another benefit. This insurance pays you once for each eligible illness. However, the diagnoses must be at least 90 days apart, and the conditions can't be related to each other. Critical Illness rates are based on your age when you first enroll and will not change as you get older. Critical Illness premium rates will be available during the online enrollment process. This plan covers:

- Heart attack
- Blindness
- Major organ failure
- End-stage kidney failure
- Benign brain tumor
- Coronary artery bypass surgery
- Coma that lasts at least 14 consecutive days
- Stroke whose effects are confirmed at least 30 days after the event
- Occupational HIV
- Permanent paralysis of at least two limbs due to a covered accident

Coverage is also included for:

- Cancer
- Carcinoma in situ — pays 25% of your coverage amount. (Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.)

The plan includes a Wellness Benefit. Every year, each family member who has Critical Illness coverage can also receive $50 for getting a health screening test, such as Blood tests, Chest X-rays, Stress tests, Colonoscopies, Mammograms, and other tests listed in your policy.

Retirement Plan

One of the best ways to save for your retirement is to participate in GACS' retirement plan, which is administered by Principal Financial Group. Both part-time and full-time employees who are age 21+ may participate in the retirement plan. GACS provides a matching contribution of 5%, with an additional 1% at the 5% level. GAC's match is **67% on the first 9% of pay you contribute** per pay period. The match formula provides a 6% matching contribution (if the employee is contributing at the 9% level) from GAC while helping you to be on track for a successful retirement. To be eligible for the matching retirement contribution, an employee must have completed two years of full-time employment with GACS and be age 21 or over. Full-time employment for this purpose is defined as working a minimum of 1,000+ hours annually.

You may start or stop contributions to the retirement plan directly through Principal Financial Group's website (**www.principal.com)** at any point during the employment year. **You will not elect or waive participation through the Open Enrollment website, but rather directly through Principal's website.** Principal Financial Group provides comprehensive resources, tools and benefits for participants, including a mobile app, one-on-one consultation with a licensed, experienced financial counselor, and RetireView – a robust, user-friendly asset allocation service for selecting an investment portfolio to fit your risk preference and retirement time horizon. **When you enroll and set up your online account on Principal's website, be sure to designate your beneficiary.**

GAC Legacy Society

Members of the GAC Legacy Society have found GAC's work so important that they name GAC as one of their beneficiaries of their last will and testament, trust, life insurance, or retirement plans. For further information, contact the Advancement Office.

Short-Term Disability Plan

The Short-Term Disability Plan by Lincoln Financial Group provides up to 60% of base pay up to a $1,000 weekly maximum after a 15-day elimination period up to a maximum of 26 weeks. Sick leave or unpaid time must be used during the 15-day elimination period. Coverage is available on the first day of the month following an employee's election. Coverage ceases when employment with GACS ends. For further information, contact Lincoln Financial Group at **1-800-423-2765** or visit the website at **www.lincoln4benefits.com.**

College Student Loan or Savings Matching Plan

Employee Choice, a benefit program administered by BenefitEd, will be available to Greater Atlanta Christian School employees with student loans or 529 College Savings Plans. This program allows employees to elect their match funds toward their retirement plan, student loan, 529 College Savings Plans or a combination, whichever option fits your needs. As to the 529 College Savings Plan, it can be set up for anyone – it does not have to be only for a dependent child.

After two years of full-time employment, employees are eligible for Employee Choice. Greater Atlanta Christian School currently matches retirement plan contributions .67% up to 9% through Principal Financial Group. This means that if you contribute 9% from your paycheck you will get the maximum match of 6% from Greater Atlanta Christian School.

Once you're eligible for Employee Choice, you'll receive an email from BenefitEd inviting you to enroll in the program. When participating in Employee Choice, here's a few things to keep in mind:

- Student loan or 529 College Savings Plan match contributions through Employee Choice are considered taxable income for the employee.
- The employee must be the borrower or account holder of any student loan or 529 College Savings Plan registered during enrollment. 529 College Savings Plans can have beneficiaries that are not employees of Greater Atlanta Christian School.
- 529 College Savings Plan accounts must be open and active before enrolling in Employee Choice.
- Greater Atlanta Christian School will match retirement plan contributions first, so you must be contributing less than 9% or not at all to the retirement plan to receive match funds toward your student loan or 529 College Savings Plan.
- BenefitEd is not Greater Atlanta Christian School's retirement plan record keeper so any change to your retirement plan election must be made directly with Principal Financial Group.
- Employee contributions toward student loan repayment or 529 College Savings Plan payment are through payroll deductions per month.

If you have questions regarding the Employee Choice program please contact BenefitEd's Customer Service team at support@youbenefited.com or 1-844-358-5707.

Additional Benefits

Credit Union

The Credit Union offers employees checking, loans, investments, and savings account services with competitive rates. Georgia United Credit Union provides the credit union services. They provide unparalleled member service experience and strive to meet each member's unique financial needs with the products and services most relevant to them. You may contact them at **(770) 476-6400** or **https://gucu.org**.

Dining Program

All employees have full access to the GACS Dining Program at no out-of-pocket cost. It is not a taxable benefit. Any employee, whether part-time or full-time, who is working at lunchtime on a school day may receive this benefit. The Dining Program benefit is a "dine in" benefit in one of GACS' dining halls. This is both to eliminate disposable containers and their associated costs (like styrofoam which is a sustainability no-no) as well as to build a stronger sense of the GACS community – staff, students, and teachers together.

Employee Activity Pass

Issued at the beginning of each school year, the GACS Employee (Staff) Activity Pass provides employees and members of their immediate family free admission to all GACS regular season home athletic and fine arts events. This benefit extends to children of GACS employees until 22 years of age as long as they provide their ID card. Employees may pick up cards for their children not enrolled at GACS in the President's Office.

Employee Assistance Program

Provided at no cost to the employee, the Employee Assistance Program (EAP) is a 24-hour, seven days a week confidential telephone consultation service. You may contact them at **1-888-628-4824** or **www.GuidanceResources.com.com (username is LFGsupport and password is LFGsupport1)**. Staffed by licensed mental health professionals, the EAP provides assistance with a variety of day-to-day issues including but not limited to:

- Managing stress
- Balancing work and life
- Exploring career development options
- Working through grief and loss issues
- Quitting tobacco, alcohol or drug use
- Handling relationships
- Caring for children or aging parents
- Dealing with conflict or violence
- Controlling depression and anxiety

Encore Kids Program

The Encore Kids Program provides onsite care for students during off school time periods, except for the months of June and July. Employees whose children are enrolled at GACS receive a 50% discount on the Encore Kids Program, except for Discovery activities.

Life Insurance

GACS provides all eligible full-time employees with basic life insurance coverage in the amount of $50,000. The life insurance policy is provided through Lincoln Financial Group and is portable upon separation from GACS.

Additional Benefits (continued)

Long-Term Disability Insurance

Long-term disability insurance is provided by Lincoln Financial Group as a GACS paid benefit for all eligible full-time employees. It provides you partial protection if a serious illness or injury causes you to be absent from work for an extended period of time. Coverage is for 60% of your pre-disability monthly earnings, not to exceed $5,000. Your benefit would begin after 180 days of the onset of your disability and benefits are payable for the duration of your disability up to age 65, or your Social Security normal retirement age.

Mobile Phone Service Discount

On behalf of its employees, GACS negotiated a corporate partnership with Verizon. All employees are eligible for a 14% discount (17% if you go paperless) on any or all personal cellular plans with Verizon for the employee or their entire family.

Spartan Store Discount

The Spartan Store provides convenient access to products and services that benefit the GACS community. Employees receive a 20% discount on select items (excluding uniforms). Sales tax is not applied to Spartan Store purchases. Employees may pay for purchases through either cash, check, credit card, store account, or payroll deduction.

Student Tuition Discount

Children of GACS employees who are enrolled at GACS are eligible for a tuition discount (remission) based on the position held and total hours worked annually. GACS tuition payments may be made through monthly payroll deduction or direct payment to Student Accounts on a monthly, quarterly or annual payment schedule.

Summer Camp

Summer Camp is a program offered during June and July for the care of children which provides engaging, fun activities. Employees whose children are enrolled at GACS receive a 25% discount on the Summer Camp program, except for Specialties.

Will Preparation Services

Will Preparation Services are available through Lincoln Financial Group for you and your spouse. The types of legal documents provided are will, living will, healthcare power of attorney, and financial power of attorney. The service fees are fully paid by GACS. For more information on how these services can protect you, contact Lincoln Financial Group at **1-855-891-3684** or **www.GuidanceResources.com**.

Benefit Resource Center (BRC)

With GACS's benefit plans, you now have access to personal benefit specialists, who are ready to provide individualized assistance with a range of benefits and insurance-related needs.

Services include:

- Plan Support – Answer questions regarding general plan inquiries for health and other benefits
- Employee Advocacy Services – Transfer and facilitate calls with insurance vendors/carriers
- Claims Appeal Help – Provide claim appeals information and help resolve claim payment issues

How it works:

- Employee or family member calls the Benefit Resource Center at 855-874-0835

- Caller speaks to a dedicated benefits specialist and receives live, individualized assistance

- Benefits specialist continues to support the individual until the issue is resolved

Convenient Access

Personal benefit specialists are available Monday through Friday between 8 a.m. and 5 p.m. ET at 855-874-0835. You can also send an e-mail to BRCSouth@usi.com to receive advocacy services and to learn more about your benefit plans.

Important Dates

This Open Enrollment season, keep in mind these important dates for the upcoming year.

Key Dates:

July 27, 2020	Open Enrollment begins at 12:00 a.m., Eastern Standard Time. Enroll on https://login.paylocity.com
July 27-August 9	Meet with HR and/or view Open Enrollment webinar to learn more and ask questions about your 2020-21 benefits.
August 9, 2020	Open Enrollment ends at 11:59 p.m., Eastern Standard Time.
September 1	All 2020-21 GACS benefits go into effect.
September 15	Review your paycheck for new compensation and deduction amounts.
Fall Semester	Appointment with Principal Financial Group financial advisor to review retirement plan and obtain assistance with planning or setup.
Late February 2021	Download your 2020 W-2 from Paylocity.
June 1	Deadline for submission of Annual Physical Certification and completion of your Aetna online Health Risk Assessment (for covered medical plan enrollees with the Wellness premium). Deadline for completion of one online Aetna Journey for GAC HSA contribution.
August 31, 2021	Deadline to incur expenses for FSA healthcare and dependent care plans.
October 31, 2021	Deadline to submit expenses for all FSA healthcare and dependent care plans.

Additional Notices and Disclosures

ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. GACS will distribute all federally required annual notices upon hire and during each annual Open Enrollment period. Annual notices will also be posted on our Paylocity website (https://login.paylocity.com) for you to download and read at your convenience.

Annual Notices

- **Medicare Part D Notice of Creditable Coverage:** Plans are required to provide each covered participant and dependent a Certificate of Creditable Coverage to qualify for enrollment in Medicare Part D prescription drug coverage when qualified without a penalty. This notice also provides a written procedure for individuals to request Certificates of Creditable Coverage.

- **HIPAA Notice of Privacy Practices:** This notice is intended to inform employees of the privacy practices followed by GACS' group health plan. It also explains the federal privacy rights afforded to you and the members of your family as plan participants covered under a group plan.

- **Women's Health and Cancer Rights Act (WHCRA):** The Women's Health and Cancer Rights Act (WHCRA) contains important protections for breast cancer patients who choose breast reconstruction with a mastectomy. The U.S. Departments of Labor and Health and Human Services are in charge of this act of law which applies to group health plans if the plans or coverage provide medical and surgical benefits for a mastectomy.

- **Newborns' and Mothers' Health Protection Act:** The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time a mother and her newborn child are covered for a hospital stay following childbirth.

- **Special Enrollment Rights:** Plan participants are entitled to certain special enrollment rights outside of GACS' Open Enrollment period. This notice provides information on special enrollment periods for loss of prior coverage or the addition of a new dependent.

- **Medicaid & Children's Health Insurance Program:** Some states offer premium assistance programs for those who are eligible for health coverage from their employers, but are unable to afford the premiums. This notice provides information on how to determine if your state offers a premium assistance program.

- **Summary of Benefits and Coverage (SBC):** Health Insurance issuers and group health plans are required to provide you with an easy-to-understand summary about your health plan's benefits and coverage. The new regulation is designed to help you better understand and evaluate your health insurance choices.

Disclosures

The terms "you" and "your" as used in this document refer to an employee of Greater Atlanta Christian School who meets all the eligibility and participation requirements for each of the benefit plans. Receipt of this document does not guarantee that the recipient is a participant under the Plans and/or otherwise eligible for benefits under the Plans.

GACS reserves the right to make changes or to terminate any benefit plan or plans at any time, without prior notice to or consent from any employee, former employee or participant. If there is any inconsistency between this document and the official plan documents and contracts, the official plan documents and contracts will control.

This document is a Summary of Material Modifications (SMM) under the applicable Plans, within the meaning of Section 104 of ERISA.

Important Notice from Greater Atlanta Christian School, Inc. About Your Prescription Drug Coverage and Medicare

Medicare Part D Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Greater Atlanta Christian School, Inc. 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. Greater Atlanta Christian School, Inc. has determined that the prescription drug coverage offered by the Aetna High Deductible with HSA Classic Plan, HSA Saver Plan, and Select 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.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Greater Atlanta Christian School, Inc. coverage will be affected.
If you joined a Medicare drug plan after a COBRA qualified event, your COBRA coverage may end.
If you do decide to join a Medicare drug plan and drop your current Greater Atlanta Christian School, Inc. coverage, be aware that you and your dependents will 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 Greater Atlanta Christian School, Inc. 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 Greater Atlanta Christian School, Inc. 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:	August 1, 2020
Name of Entity/Sender:	Greater Atlanta Christian School, Inc.
Contact--Position/Office:	Deborah DeBoer
Address:	1575 Indian Trail Lilburn Road, Norcross, GA 30093
Phone Number:	770-243-2241

The Women's Health Cancer Rights Act of 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: HSA Classic (EE Deductible: $3,275 / Coinsurance: 100%), HSA Saver (EE Deductible: $5,000 / Coinsurance: 100%), and Select Plan (EE Deductible: $2,000 / Coinsurance: 80%).

Newborns Act Disclosure – Federal

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

Notice of Special Enrollment Rights

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

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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

Notice Regarding Wellness Programs

The GACS Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you, as well as a participating spouse, choose to participate in the wellness program you will be asked to complete an annual physical and a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease).

Employees who choose to participate in the wellness program by completing an annual physical/wellness visit and completing an online Health Risk Assessment, will be rewarded with the Wellness premium rate, which is $125.00 lower per month. In addition, if you, and your participating spouse, each complete one Online Aetna Journey Health program by given deadline, then GACS will contribute $300 to your HSA fund upon completion. Lastly, for completion of the Aetna HRA and Health Program, you will receive a $50.00 gift card through Aetna's rewards website.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Deborah DeBoer at 770-243-2241.

The information from your annual physical/wellness visit, your HRA and the information your provide for your Journey Health Program will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as coaching programs. You also are encouraged to share your results or concerns with your own doctor.

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Deborah DeBoer at 770-243-2241.

Wellness Program Disclosure
Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Deborah DeBoer at 770-243-2241 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 per day (up to a $1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Questions regarding any of this information can be directed to:
Deb DeBoer
1575 Indian Trail - Lilburn Road , Norcross, Georgia United States 30093, T: 404-233-5332
DDeBoer@greateratlantachristian.org

Notice of HIPAA Privacy Practices – Effective September 1, 2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

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

  Marketing purposes

  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

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

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

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

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

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

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

Changes to the Terms of this Notice

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

Other Instructions for Notice

- September 1, 2020
- Deborah DeBoer, Director, Human Resources

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

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

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

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

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

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

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/defualt.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

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

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2020)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 5-31-2020)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost–sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Greater Atlanta Christian School. Inc.	4. Employer Identification Number (EIN) 58-0960612	
5. Employer address 1575 Indian Trail Lilburn Road	6. Employer phone number 770-243-2241	
7. City Norcross	8. State GA	9. ZIP code 30093
10. Who can we contact about employee health coverage at this job? Deborah DeBoer		
11. Phone number (if different from above)	12. Email address DDeBoer@greateratlantachristian.org	

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

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

  [X] All employees. Eligible employees are:

  Employees working at least 30 hours per week.

  [ ] Some employees. Eligible employees are:

- With respect to dependents:

  [X] We do offer coverage. Eligible dependents are:

  Legal spouse and dependent children up to age 26.

  [ ] We do not offer coverage.

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

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

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

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)