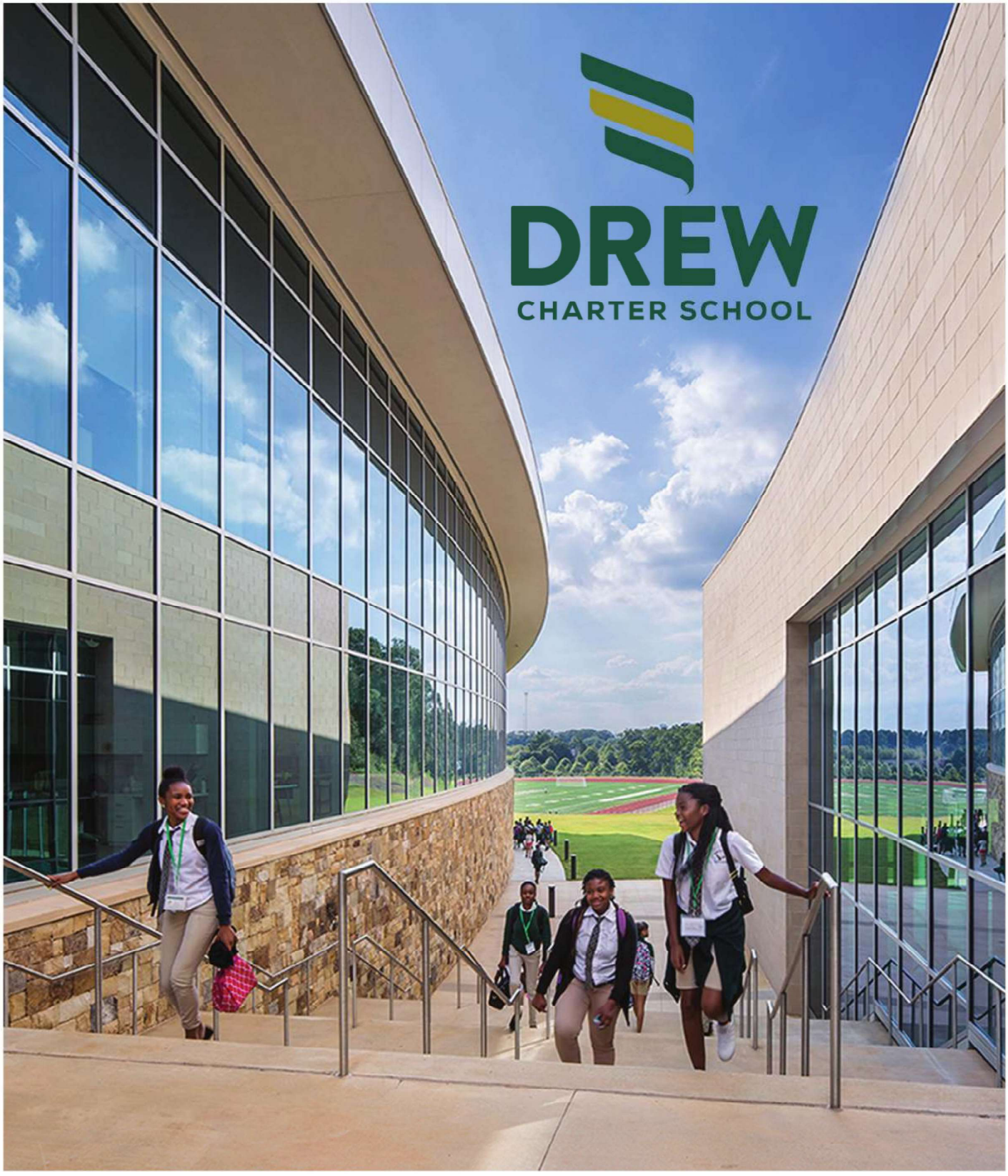

BENEFITS-IN-BRIEF

PLAN YEAR 2019 - 2020

DREW
CHARTER SCHOOL

Charles R. Drew Charter School opened in 2000 as the City of Atlanta's first public charter school. Drew's innovative Project-Based Learning (PBL) approach with an integration of the STEAM (Science, Technology, Engineering, Arts, and Mathematics) curriculum and a strong foundation in literacy helps all students reach their highest potential. Serving more than 1,700 students (Pre-K through 12th grade), Drew represents the cradle-to-college pipeline in the East Lake community and is an integral part of a holistic neighborhood revitalization led by the East Lake Foundation.

Mission: Drew Charter School is an exemplary, innovative education community that empowers all students to achieve their full potential.

Philosophy: Drew Charter School's approach is based on the belief that every child has gifts and talents that must be discovered and nurtured. All students are consistently encouraged to strive to do their best so they may reach their highest potential. A Drew education is one that supports strong intellectual, physical, social, and emo- tional growth.

Employees: Drew Charter School values its employees and recognizes the significant work and contributions of the staff in the school living its mission and achieving its goals. As one way of supporting its employees, Drew seeks to offer excellent, competitive benefits, at the lowest cost possible, to promote the health and wellness of employees and their families.

As Drew prepares for the 2019 – 2020 school year, employees are encouraged to carefully review all of the benefit plan options and costs available for the new benefit year in order to make the best, most informed benefits decision for themselves and their eligible family members.

Please note: This guide contains the basic information about your benefits program. It does not cover every provision, limitation or exclusion, but it does provide a general description of each benefit plan. Every effort has been made to ensure that the information is accurate. However, the guide is not an insurance policy. If there is any question as to coverage, benefit eligibility or interpretation, the insurance contract and the Certificate of Coverage you receive from the insurance carrier will govern the administration of your benefits. If you would like additional or specific information, please contact the Human Resources department.

WHO IS ELIGIBLE

To qualify for Drew Charter School's benefits, you must be a regular, full-time active employee averaging 30 hours or more per week. Once you become eligible to participate in the programs, you may also enroll your eligible dependents for medical, dental and vision coverage. An eligible dependent includes any of the following:

- Legal Spouse as defined by the state in which you were married;
- Domestic Partners (please see page 4 for the requirements for enrolling a domestic partner);
- Your dependent children under 26 years of age who are:
  - Your biological children
  - Your stepchildren
  - Your legally adopted children, including any children placed with you for adoption
  - Your Domestic Partner's biological or legally adopted children
  - Children for whom you are responsible pursuant to an existing/current court order; or
  - Your unmarried child of any age who is medically certified as disabled and dependent on the parent. ***Please note:*** If your child is 26 or older but remains eligible because he/she is handicapped, it is your responsibility to inform Drew Charter School's Human Resources Department of your child's status and to provide supporting documentation. If you cannot, or do not, present supporting documentation to Drew Charter School's Human Resource Department, benefits for these dependents will end on the last day of the month in which the dependent turns age 26.

HOW TO ENROLL

Drew Charter School is using the Benefits Connect online system for enrollment. Online enrollment with Benefits Connect is simple, secure and can be done in a few minutes from any computer with internet access. After enrolling online, you will have access to your benefit information 24 hours a day, from any computer. Follow the steps below to learn how to access the system and enroll.

Log on to ***www.benefitsconnect.net/drewcharter***. Initially your user name and password are defaulted to a standard format. Upon completing your first login, you will be prompted to change your password. Your user name is made up of the first six letters of your last name, followed by your first initial and the last four numbers of your social security number. The initial password for the system is your social security number (without dashes). Note: If your last name is not six letters, please use your entire last name, first initial and last four numbers of your social security number as your username.

Example:

Employee Name: Matt Sample

Social Security Number: 949-12-1234

User Name: samplem1234

Password: 949121234

Please see HR if you have any log in issues.

IMPORTANT INITIAL ENROLLMENT NOTIFICATION: If you decline coverage when you first become eligible for a benefit, please be aware that you will be considered a late enrollee at any future election opportunities and, as such, may be subject to benefit limitations or be required to provide evidence of insurability.

WHEN TO ENROLL

NEWLY HIRED EMPLOYEES:

Within 30 days of the date of hire, as a newly hired employee, you will need to complete the online enrollment process to elect any coverage for which you are eligible and want to participate. Coverage will begin the first of the month following 30 days of active employment.

HOW TO MAKE CHANGES

Unless you have a qualified change in status, such as a change in family status or an employment event, you cannot make changes to the benefits you elect until the next open enrollment period. Please see below for additional details.

CHANGE IN FAMILY STATUS AND EMPLOYMENT EVENTS

If any of the following life events occur during the plan year, you must inform the HR department within 30 days of such event or you will be unable to make any changes to your plan. Contact HR for more information about any of the following life events:

- Birth, adoption, or placement for adoption of a dependent child
- Marriage, divorce or legal separation
- Dependent child loses eligibility for coverage
- Death of spouse or dependent child
- Dependent spouse or child gains or loses employment or coverage under their employer's plan
- You or your spouse begin or return from an approved leave of absence
- COBRA coverage under another health plan is exhausted
- Change in employment status for you, your spouse, or dependent that affects your health care coverage (such as termination of employment)
- Entitlement to, or loss of, Medicare or Medicaid benefits

DOMESTIC PARTNER COVERAGE

To be eligible for coverage, Drew Charter School requires that domestic partners be in a committed relationship for at least one year. Also, to meet the criteria of domestic partner coverage under the Drew Charter School Benefits Program, you must provide the following documentation to HR:

- A notarized Affidavit of Domestic Partnership;
- Proof of Joint Residency; and
- Proof of Financial Interdependency

Any contributions made by you for a domestic partner and his or her eligible dependents must be made on an after-tax basis. The cost for domestic partner coverage, less any contributions you make for that coverage, will be reflected as imputed income on your paycheck.

MEDICAL INSURANCE

Drew Charter School offers an excellent health insurance program that consists of three comprehensive healthcare plan options through Cigna. Employees will have a choice between three traditional copay medical plans.

DEFINITIONS:

Deductible: An amount during the calendar year an insured pays before the insurer makes payment for covered medical services.

Coinsurance: After the deductible has been satisfied, the plan will share costs according to the percentage level shown. Coinsurance continues to apply until a member has reached their out of pocket maximum for the calendar year.

Co-Pay: A fixed dollar amount required by an insured at the time a medical service is received. Usually applies to an office visit or a prescription drug purchase

Out of Pocket Maximum: The maximum amount a member will have to pay under the health plan in a calendar year. This maximum will include the plan deductible and co-pays.

Lifetime Maximum: The maximum amount your health plan will pay out in benefits over the time you are insured under the plan

Cigna - Medical Plan Options

	OAP Plan I		OAP Plan II		OAP Plan III	
	IN NETWORK	NON NETWORK	IN NETWORK	NON NETWORK	IN NETWORK	NON NETWORK
OFFICE COPAY (PCP/SPECIALIST)	$30 / $90	60% After Ded	$25 / $40	60% After Ded	$20 / $40	60% After Ded
PRESCRIPTION DRUGS						
DEDUCTIBLE	NA		NA		NA	
Generic	$15		$15		$15	
Formulary	$45		$45		$45	
Non-Formulary	$85		$85		$85	
MAIL ORDER (90 DAY SUPPLY)	2.5 x Retail		2.5 x Retail		2.5 x Retail	
ANNUAL DEDUCTIBLE*						
INDIVIDUAL	$500	$1,000	$2,000	$2,000	$500	$2,000
FAMILY	$1,000	$2,000	$4,000	$4,000	$1,000	$4,000
COINSURANCE	80%	60%	100%	60%	90%	60%
OUT-OF-POCKET MAX	Includes Deductible and Copays		Includes Deductible and Copays		Includes Deductible and Copays	
INDIVIDUAL	$3,500	$7,000	$6,000	$12,000	$3,000	$12,000
FAMILY	$7,000	$14,000	$12,000	$24,000	$6,000	$24,000
EMERGENCY ROOM	$350 Copay		$150 Copay		$150 Copay	
URGENT CARE	$100 Copay	60% After Ded	$75 Copay	60% After Ded	$75 Copay	60% After Ded
INPATIENT HOSPITAL	80% After Ded	60% After Ded	100% After Ded	60% After Ded	90% After Ded	60% After Ded
OUTPATIENT FACILITY	80% After Ded	60% After Ded	100% After Ded	60% After Ded	90% After Ded	60% After Ded
PREVENTIVE						
PHYSICAL (ADULT)	Plan pays 100%	60% After Ded	Plan pays 100%	60% After Ded	Plan pays 100%	60% After Ded
WELL CHILD	Plan pays 100%	60% After Ded	Plan pays 100%	60% After Ded	Plan pays 100%	60% After Ded
LIFETIME MAXIMUM	Unlimited		Unlimited		Unlimited	

**PLEASE NOTE: DEDUCTIBLES RUN FROM JANUARY 1ST THROUGH DECEMBER 31ST.*

YOUR COSTS IN 2019 / 2020 - BI-WEEKLY PAYROLL DEDUCTIONS

EMPLOYEE ONLY	$54.82	$53.68	$67.13
EMPLOYEE/DEPENDENT	$115.13	$112.72	$140.97
EMPLOYEE/CHILD(REN)	$104.16	$101.99	$127.55
FAMILY	$164.47	$161.04	$201.39

MEDICAL INSURANCE (CONT)

Finding a Doctor:

1. Go to www.Cigna.com, click on FIND A DOCTOR at the top of the screen. Then select "plans through your employer."
2. Enter the geographic location you want to search.
3. Select the Open Access Plan, OA Plus, Choice Fund OA Plus Option under Medical Plans.
4. Enter a name, specialty or other search word. Click SEARCH to see your results.

Introducing Cigna Telehealth Connection:

Cigna provides access to two telehealth services as part of your medical plan - Amwell and MDLive.

Cigna Telehealth Connection lets you get the care you need - including most prescriptions- for a wide range of minor conditions. Now you can connect with a board-certified doctor via video chat or phone, without leaving your home or office. When, where and how it works best for you!

Choose When: Day or night, weekends, and holidays.
Choose Where: Home, work or on the go
Choose How: Phone or video chat
Choose Who: Amwell or MDLIVE Doctors

Amwell and MDLIVE's doctors can diagnose you, prescribe medication when appropriate and send the prescription directly to your pharmacy. Appointments can take place on a mobile device or online. Virtual visits can be used to talk to a doctor about many conditions, including:

- Acne
- Allergies
- Bronchitis
- Cold & Flu
- Stomachache
- Ear Aches
- Fever
- Head Ache
- Infections
- Insect Bites
- Nausea
- Pink Eye
- Rashes
- Respiratory
- Sinus Infection
- Skin Infections
- Sore Throat
- Urinary Tract Infections

COST SAVINGS:

Televists with Amwell and MDLIVE cost less than going to a convenience or urgent care clinic, and significantly less than going to the emergency room. And the cost of a phone or on-line visit is the same or less than with your primary care provider. These services should be used for non-life threatening conditions.

How it works:

1. Set up and create and account with one or both Amwell and MDLIVE
2. Complete a medical history using their "virtual clipboard"
3. Download vendor apps to your smartphone/mobile device

Website and Contact:

MDLIVEforCigna.com
888-726-3171

AmwellforCigna.com
885-667-9722

DENTAL

Our dental plan is offered through MetLife. This dental plan encourages preventive care and provides coverage for a wide range of dental services to you and your dependents. You may seek treatment from the dentist of your choice through this dental plan. However, by choosing a dentist that participates in the MetLife dental network, you will generally reduce your out-of-pocket expenses. Please visit www.metlife.com/dental to search for in-network dentists or call 800-942-0854 for assistance.

SERVICE	IN-NETWORK	OUT-OF-NETWORK
Deductible*	$100 (3 per family)	$100 (3 per family)
Preventive Services	100%, no deductible	100% of R&C Fee**, no deductible
Basic Services	80% after deductible	80% of R&C Fee**, after deductible
Major Services	50% after deductible	50% of R&C Fee**, after deductible
Annual Maximum	$3,000	$3,000
Child Orthodontia (up to age 19)	50% up to $2,000 lifetime maximum	50% up to $2,000 lifetime maximum

PLEASE NOTE: DEDUCTIBLES RUN FROM JANUARY 1ST THROUGH DECEMBER 31ST.

***** REASONABLE AND CUSTOMARY FEE IS DETERMINED BASED ON WHAT 90% OF DENTISTS IN SAME GEOGRAPHIC AREA CHARGE***

Preventive Services: Oral Exams, Cleanings, X-Rays, Fluoride

Basic Services: Fillings, Simple Extractions, Space Maintainers, Endodontics (Root Canal), Periodontics

Major Services: Crowns, Inlays/Onlays, Bridges, Dentures, Oral Surgery

EMPLOYEE PAYROLL DEDUCTIONS - BI-WEEKLY				
	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
Dental	$3.79	$8.79	$10.74	$17.10

VISION

Drew Charter School is pleased to offer you a quality and affordable Vision plan through MetLife. Employees can choose from one of the largest networks of ophthalmologists, optometrists, and opticians in the nation. For Eyes, Visionworks, Costco and JCPenny are just a few of the contracted retailers. To look up in-network providers in your area, visit www.metlife.com/mybenefits.

METLIFE VISION	
Exams	$10 copay
Frames/Lenses/Contacts	$25 copay
Frames/Contacts Allowance	$130 allowance
Exam Frequency	1 X PER 12 MONTHS
Lenses Frequency	1 X PER 12 MONTHS
Frames Frequency	1 X PER 24 MONTHS

EMPLOYEE PAYROLL DEDUCTIONS - BI-WEEKLY				
	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
VISION	$3.27	$6.55	$5.54	$9.15

DISABILITY INCOME BENEFITS

Drew Charter School provides full-time employees with short and long-term disability income benefits and pays the full cost of this coverage. In the event you become disabled by an injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

	SHORT-TERM DISABILITY	LONG-TERM DISABILITY
Benefits Begin	7th day after an injury or illness	After 90 days of Disability
Benefits Payable	For 12 weeks	To Social Security Normal Retirement Age
Percentage of Income Replaced	70%	60%
Maximum Benefit	$1,000 / week	$10,000 / month

BASIC LIFE AND AD&D INSURANCE

Drew Charter School provides full-time employees with group life and accidental death and dismemberment (AD&D) insurance in an amount equal to two times your base annual earnings, up to $500,000 and pays the full cost of this benefit. Please make sure we have your correct beneficiary information on file.

VOLUNTARY LIFE INSURANCE

Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself and your dependents in this benefit, you pay the full cost through payroll deductions. You must enroll yourself if you wish to insure your dependents.

Please see below for the amounts that are Guarantee Issue. Guarantee Issue is the amount of Voluntary Life insurance you can elect at date of hire without having to provide evidence of insurability. Any amount over and above what is Guarantee Issue will be subject to medical underwriting. An Evidence of Insurability (EOI) form will need to be completed. If you originally declined voluntary life and now want to enroll, any amount you elect will be subject to EOI.

	GUARANTEE ISSUE	BENEFIT
Employee Benefit	$150,000	May elect in $10,000 increments up to 5 times your annual salary to a maximum of $500,000
Spouse Benefit	$25,000	May elect in $5,000 increments, not to exceed 50% of the employee amount, to $100,000
Child(ren) Benefit	$10,000	May elect $1,000, $2,000, $4,000, $5,000 or $10,000 (6 months to age 19, or 26 if full time student), $100 (15 days to 6 months)

Please see Benefits Connect to obtain rates for voluntary life.

HEALTH CARE & DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS (FSA)

Drew Charter School provides you the opportunity to pay for out-of-pocket medical, dental, vision, and dependent care expenses with pre-tax dollars through our Flexible Spending Account (FSA). You must enroll in the plan to participate for the plan year July 1, 2019 through June 30, 2020. You can save approximately 25% of each dollar spent on these expenses when you participate in a FSA. A Health Care FSA is used to reimburse out-of-pocket healthcare expenses incurred by you and your dependents. A Dependent Care FSA is used to reimburse expenses related to the care of eligible dependents while you and your spouse work, such as a licensed preschool or kindergarten, before-and-after school programs, qualified daycare centers, and elder care of an individual who is a dependent on your federal taxes.

Contributions to your FSA come out of your paycheck before any taxes are taken out. This means you don't pay federal income tax, Social Security taxes, and state and local income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you expect to pay Out-of-Pocket for eligible expenses for the plan period. Drew Charter School does allow you to roll over any remaining balance up to $500 at the end of the plan year towards the next plan year. Any amount over $500 at the end of the plan year will be forfeited.

You will receive a debit card that allows you to pay for eligible health care expenses directly from your Health Care FSA. If you receive a service that does not accept the debit card, you can file a reimbursement request by submitting a paper claim form. Approvable documentation for medical expenses, which is required by the IRS, is a receipt/statement containing, on a single document, all of the following: name of provider, date(s) of service within the plan year, an eligible type of service or product and dollar amount (after insurance, if applicable). TIP: An Explanation of Benefits (EOB) from your insurance provider is ideal for substantiating claims. To view a comprehensive list of Health Care and Dependent Care eligible expenses, please refer to the IRS publication 502: www.irs.gov/pub/irs-pdf/p502.pdf.

The maximum dollar amount you may contribute to our Flexible Spending Account this plan year is:

- **Healthcare:** $2,700
- **Dependent Care:** $5,000 (or $2,500 if married and filing separately)

How to Use a FSA

Using an FSA is easy and saves you money but requires careful planning. Calculate your anticipated out-of-pocket health care and/or dependent care expenses for the upcoming year. A good way is to look at your expenses from last year.

1. Enroll. Enter amount of your estimated, up to the maximum allowance, for the Health Care and/or Dependent Care FSA.
2. Contribute. Your allocated amount will be taken out of each paycheck in equal amounts and deposited into your account(s each pay period on a pre-tax basis.
3. Once you have incurred a qualified expense, use your debit card to pay for the health care costs or submit you claim for dependent care costs.

Always keep your receipts for one year in case you are asked to verify the expenses!

PLEASE NOTE: YOUR FSA ELECTIONS RUN JULY 1ST THROUGH JUNE 30TH.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

ComPsych Corporation is an Employee Assistance Program that helps people balance the demands of work, life, and personal issues. This confidential service provides access to professional counseling and guidance to address stressful life events. Employees and their eligible dependents can speak to a trained professional who will help assess their needs and provide referrals to local resources including psychologists, legal and financial consultants, marriage/family therapists, and substance abuse counselors. For 24/7 telephonic access, call 1.800.382.2377. Up five face-to-face counseling sessions are also available at no charge to you!

CRITICAL ILLNESS INSURANCE

Critical Illness Insurance offers a valuable safety net in the event certain serious illnesses or conditions occur. Even with medical insurance, a critical illness can result in extra out-of pocket expenses, like deductibles, co-insurance and out-of-network treatments. These expenses – along with childcare, mortgage payments and utility bills can create an additional financial burden for you and your family. Critical Illness provides you with a benefit if you, a spouse or Domestic Partner or a dependent child is diagnosed with a covered condition.

	INITIAL BENEFIT	REQUIREMENTS
Employee Benefit	Initial Benefit Amount of $15,000 or $30,000	Coverage is guaranteed provided you are actively at work.[3]
Spouse/Domestic Partner[1*]	50% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the spouse/ domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.[3]
Dependent Child(ren)[2*]	50% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.[3]

Benefits will be paid as a percentage of elected coverage for the following conditions:

Covered Conditions	INITIAL BENEFIT *(First Occurrence After the Effective Date)*	RECURRENCE BENEFIT
Full Benefit Cancer	100% of Benefit Amount	50%
Partial Benefit Cancer	25% of Benefit Amount	12.5%
Heart Attack	100% of Benefit Amount	50%
Stroke	100% of Benefit Amount	50%
Coronary Artery Bypass Graft	100% of Benefit Amount	50%
Kidney Failure	100% of Benefit Amount	50%
Alzheimer's Disease	100% of Benefit Amount	NONE
Any of the 22 Listed conditions	25% of Benefit Amount	NONE
Major Organ Transplant	100% of Benefit Amount	NONE

Listed Conditions: Receive 25% of the initial benefit amount for 22 conditions:

- Addison's disease (adrenal hypo function); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematous (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

Health Screening Benefit:

- If a covered person takes one of the screening/prevention measures listed below while such covered person is insured under the Certificate and after his/her insurance has been in effect for 1 month, MetLife will pay a health screening benefit upon submission of proof that such measure was taken. When MetLife receives such proof, MetLife will review it, and if MetLife approves the claim, MetLife will pay a health screening benefit of $50 if the insured purchased a $15,000 Benefit Amount or $100 if the insured purchased a $30,000 Benefit Amount.

CRITICAL ILLNESS INSURANCE (CONT.)

- The covered tests are: blood test to determine total cholesterol; blood test to determine triglycerides; breast MRI; breast sonogram; breast ultrasound; carotid doppler; colonoscopy; digital rectal exam (DRE); electrocardiogram (EKG); endoscopy; fasting blood glucose test; fasting plasma glucose test; flexible sigmoidoscopy; hemocult stool specimen; mammogram; pap smears or thin prep pap test; prostate-specific antigen (PSA) test; serum cholesterol test to determine LDL and HDL levels; stress test on bicycle or treadmill; two hour post-load plasma glucose test; or virtual colonoscopy.

- MetLife will only pay one health screening benefit per covered person per calendar year.

*__PLEASE NOTE:__ The critical illness plan does have a pre-existing condition exclusion. Pre-existing Condition means a sickness or injury for which, in the 3 months before you enroll in the critical illness plan:

- Medical advice, treatment or care was sought, or, recommended by, prescribed by or received from a Physician or other Practitioner of the Healing Arts; or

- Symptoms, or any medical or physical conditions existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment.

MetLife will not pay benefts for covered conditions that are caused by or result from a pre-existing condition as defned above if the condition occurs during the frst 6 months of enrollment in the plan. This provision does not apply to benefts for heart attack or stroke.

Employee Payroll Deductions for $1,000 of Coverage – Bi-Weekly

Attained Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse / Children
<25	$0.16	$0.28	$0.30	$0.41
25–29	$0.17	$0.30	$0.30	$0.43
30–34	$0.24	$0.41	$0.37	$0.54
35–39	$0.34	$0.57	$0.47	$0.71
40–44	$0.52	$0.87	$0.65	$1.00
45–49	$0.78	$1.30	$0.91	$1.43
50–54	$1.10	$1.86	$1.24	$1.99
55–59	$1.52	$2.61	$1.65	$2.74
60–64	$2.19	$3.81	$2.33	$3.94
65–69	$3.29	$5.71	$3.42	$5.85
70+	$5.14	$8.72	$5.28	$8.85

Multiply the per $1,000 rates shown above by the coverage amount factor applicable for the employee (e.g., 15 for $15,000 of coverage) and round to two decimals to calculate rates for the quoted benefit amounts. Note that the per $1,000 rates are only applicable to the benefit amounts shown in this guide. Final implemented rates may vary slightly due to rounding.

ACCIDENT INSURANCE

Drew Charter School is pleased to offer you another opportunity for financial protection through MetLife's Group Accident Insurance as part of our robust portfolio of voluntary products. MetLife Accident Insurance can complement existing medical coverage and help fill financial gaps caused by out-of-pocket expenses such as deductibles, co-payments, and non-covered medical services caused by an accident or injury. Employees are paid a lump-sum benefit that they can use as they feel necessary. Benefits are paid regardless of what is covered by medical insurance. Payments are made directly to covered employees to spend as they choose.

Please see below for information on covered benefits.

BENEFITS			LOW PLAN			HIGH PLAN		
Category	**Subcategory**	**Benefits**	**Employee**	**Spouse**	**Child**	**Employee**	**Spouse**	**Child**
Death	Accidental Death	Basic Accidental Death Benefit	$25,000	$12,500	$5,000	$50,000	$25,000	$10,000
		AD Common Carrier Benefit	$75,000	$37,500	$15,000	$150,000	$75,000	$30,000
Accidental Dismemberment/ Functional Loss/ Paralysis Benefits	Basic Dismemberment/ Functional Loss Benefit	Loss of one finger or one toe	$250	$250	$250	$500	$500	$500
		Loss of one arm or one leg	$2,500	$2,500	$2,500	$10,000	$10,000	$10,000
		Loss of one hand or one foot	$2,500	$2,500	$2,500	$10,000	$10,000	$10,000
		Loss of two or more fingers or toes in any combination	$500	$500	$500	$1,000	$1,000	$1,000
		Loss of sight in one eye	$2,500	$2,500	$2,500	$10,000	$10,000	$10,000
		Loss of hearing in one ear	$2,500	$2,500	$2,500	$10,000	$10,000	$10,000
	Catastrophic Dismemberment/ Functional Loss Benefit	Loss of both arms or both legs or one arm and one leg	$10,000	$10,000	$10,000	$50,000	$50,000	$50,000
		Loss of both hands or both feet or one hand and one foot	$10,000	$10,000	$10,000	$50,000	$50,000	$50,000
		Loss of sight in both eyes	$10,000	$10,000	$10,000	$50,000	$50,000	$50,000
		Loss of hearing in both ears	$10,000	$10,000	$10,000	$50,000	$50,000	$50,000
		Loss of ability to speak	$10,000	$10,000	$10,000	$50,000	$50,000	$50,000
	Paralysis Benefit	Two Limbs (paraplegia or hemiplegia)	$5,000	$5,000	$5,000	$25,000	$25,000	$25,000
		Four Limbs (quadriplegia)	$10,000	$10,000	$10,000	$50,000	$50,000	$50,000

EMPLOYEE PAYROLL DEDUCTIONS – BI-WEEKLY	LOW PLAN	HIGH PLAN
Employee Only	$3.76	$7.13
Employee + Spouse	$5.83	$11.05
Employee + Children	$6.80	$12.88
Employee + Spouse/Children	$9.06	$17.16

IDENTITY THEFT PROTECTION

Identity theft has been the top consumer complaint filed with the FTC for 15 years straight. Victims are spending an exorbitant amount of time and money dealing with it. The criminals are getting smarter, and they're not going away. That's why you need an established institution that understands all the potential threats, how to prevent them and how to restore any damage done.

Drew Charter School has partnered with LifeLock to bring you identity theft protection. LifeLock Identity Theft Protection® detects your personal information in applications for credit and services within our extensive network. LifeLock monitors over a trillion data points, including those for new credit cards, wireless services, retail credit, mortgages, auto and payday loans. You can respond immediately to confirm if the activity is fraudulent with LifeLock's proprietary Not Me® verification technology. If identity fraud does occur, LifeLock's Certified Resolution Specialists are available to personally manage your case from beginning to end.

When enrolling with LifeLock, you have the choice between The LifeLock Benefit Elite plan and the LifeLock Utlimate Plus plan. The LifeLock Benefit Elite plan searches over a trillion data points every day for potential threats to your identity. It starts by looking for suspicious uses of your name, address, phone number, birth date and Social Security number to get loans, credit and services in your name. It then helps protect what might be your biggest financial assets – your 401(k) and investment accounts. The LifeLock Ultimate Plus plan provides peace of mind knowing you have the most comprehensive identity theft protection available. Enhanced services include important notifications beyond financial and credit fraud. Extra protection includes bank account activity alerts, online credit reports and credit scores.

EMPLOYEE PAYROLL DEDUCTIONS – BI-WEEKLY	LIFELOCK BENEFIT ELITE	LIFELOCK ULTIMATE PLUS
Employee Only	$3.92	$11.76
Employee + Spouse	$7.84	$23.53
Employee + Children	$6.86	$16.67
Employee + Spouse/Children	$10.78	$28.44

PRE-PAID LEGAL

Drew Charter School has also partnered with MetLaw through Hyatt Legal to give you access to quality attorneys for covered personal situations. MetLaw is a voluntary group legal plan that provides employees with convenient access to affordable legal services. Plan members may receive services through a nationwide network of more than 14,000 attorneys, or from an out-of-network attorney.

Hyatt Legal Plans has been administering group legal plans since 1981 and is the nation's largest provider of group legal plans, serving more than three million group legal plan members and dependents including 155 of the Fortune 500® companies.

MetLaw provides easy, direct access to a national network of attorneys who provide telephone advice and office consultations on an unlimited number of personal legal matters and fully covered services for the most frequently needed personal legal matters (excluding employment issues).

Examples of covered legal services include:

- Preparation of wills and trusts
- Debt matters, including identity theft defense
- Document preparation and review
- Family law, including adoptions
- Real estate matters
- Consumer protection
- Traffic and juvenile matters

Plan attorneys are carefully selected and monitored by Hyatt Legal Plans, and have an average of 25 years of experience in the practice of law.

COST PER EMPLOYEE PER MONTH (Covers Spouse and Dependents*) FOR METLAW: $24.00

COMMUTER TRANSIT BENEFITS

Drew Charter School is providing you with an opportunity to pay for out-of-pocket commuter transit expenses with pre-tax dollars through the new Commuter Transit Benefit plan offering. There are many transit options available to you; however you most likely will use an option to include commuter rail trains, commuter buses and vanpools.

Commuter benefits are flexible. You make a one-time subscription to receive the same benefits each month. Or, if your commute options change regularly, you are allowed to elect different benefits each month. It is important to note that the amount requested should be for the actual commuting expenses only.

The deadline for ordering your transit and parking benefits is the 10th of each month. You should note that IRS regulations do require you to purchase your transit benefits in advance of the month that you will use them. For example, in order to participate for the March benefit month you must purchase the benefit in February. The transit subsidy for eligible enrolled participants is a ***maximum of $265 per month***.

All employees should be aware that the amount of benefits obtained through the Pre-Tax Commuter Benefit Program should be the actual amount of the benefits needed to pay for the cost of mass transportation to and from their work place. Additionally, employees are not permitted to sell, barter, exchange or otherwise transfer cash or other goods or services obtained through use of these programs. Employees are not to return goods and services to the provider for cash or any other consideration other than for direct exchange of damaged or defective goods. You agree that you will not solicit or accept a refund or credit from any party for payments made from your account unless you return those funds to your account.

WHAT DO I NEED TO DO NOW?

All employees must login to Benefits Connect to elect or waive each coverage. Current in force benefits will roll over to 2019-2020 plan year with the exception of any FSA elections or Commuter Benefit elections. Those MUST be elected or waived for the new plan year.

Medical (Cigna)

- If you are re-enrolling, are not currently on the medical plan and wish to enroll, or if you are adding dependents to your plan you will need to enroll online using Benefits Connect. If you are waiving coverage, you will need to waive coverage through Benefits Connect.

Dental (MetLife)

- If you are re-enrolling, are not currently on the dental plan and wish to enroll, or if you are adding dependents to your plan you will need to enroll online using Benefits Connect. If you are waiving coverage, you will need to waive coverage through Benefits Connect.

Vision (MetLife)

- If you are re-enrolling, are not currently on the vision plan and wish to enroll, or if you are adding dependents to your plan you will need to enroll online using Benefits Connect. If you are waiving coverage, you will need to waive coverage through Benefits Connect.

Basic Life & Voluntary Life (MetLife)

- You are automatically enrolled in the Basic Life plan. Voluntary Life - If you are enrolling for the first time or re-enrolling in the voluntary life plan or if you want to increase your elected amount, please enroll online using Benefits Connect. If you are waiving coverage, you will need to waive coverage through Benefits Connect.

Short Term Disability and Long Term Disability (MetLife)

- You will automatically be enrolled in these plans.

Flexible Spending Account – (Employee Benefits Corporation)

- If you are enrolling for the first time or re-enrolling in the FSA, please enroll using Benefits Connect. If you are waiving coverage, you will need to waive coverage through Benefits Connect.

Commuter Transit Benefits

- If you are enrolling for the first time or waiving coverage, please do this using Benefits Connect.

Critical Illness/Accident (MetLife)

- If you are re-enrolling, are not currently on the Critical Illness/Accident plans and wish to enroll, or if you are adding dependents to your plan you will need to enroll online using Benefits Connect. If you are waiving coverage, you will need to waive coverage through Benefits Connect.

Legal (Hyatt Legal)

- If you are re-enrolling, are not currently on the Legal plan and wish to enroll, or if you are adding dependents to your plan you will need to enroll online using Benefits Connect. If you are waiving coverage, you will need to waive coverage through Benefits Connect.

Identity Theft (LifeLock)

- If you are re-enrolling, are not currently on the Identity Theft Protection plan and wish to enroll, or if you are adding dependents to your plan you will need to enroll online using Benefits Connect. If you are waiving coverage, you will need to waive coverage through Benefits Connect.

ADDITIONAL RESOURCES

FOR GENERAL BENEFIT/OPEN ENROLLMENT/ONGOING SERVICE QUESTIONS, PLEASE CONTACT:
USI Insurance | Benefit Resource Center | 855-874-0835 | BRCSouth@usi.com

FOR QUESTIONS REGARDING CLAIMS, PLEASE CONTACT:
USI Insurance | Benefit Resource Center | 855-874-0□3□ | BRCSouth@usi.com

FOR MORE INFORMATION AND TOOLS, YOU MAY REACH OUT TO OUR INSURANCE PARTNERS:

MEDICAL & PRESCRIPTION DRUG INSURANCE:
CIGNA | 1-800-244-6224 | www.mycigna.com

DENTAL INSURANCE:
METLIFE | 800-942-0854 | www.metlife.com/dental

VISION INSURANCE:
METLIFE | 800-275-4638 | www.metlife.com/vision

LIFE/AD&D AND VOLUNTARY LIFE:
METLIFE | 888-252-3607 | www.metlife.com/mybenefits

SHORT-TERM & LONG-TERM DISABILITY
METLIFE | 800-858-6506 | www.metlife.com

FLEXIBLE SPENDING ACCOUNTS (FSA):
BOON CHAPMAN | 855.516.8530 | www.boonchapman.com

EMPLOYEE ASSISTANCE PROGRAM (EAP):
COMPSYCH | 800-272-7255 | www.guidanceresources.com (WebID: COM589)

LEGAL ASSISTANCE:
HYATT LEGAL | 800-821-6400 | www.legalplans.com

IDENTITY THEFT PROTECTION:
LIFELOCK | 800-416-0599 | www.lifelock.com

CRITICAL ILLNESS/ACCIDENT:
METLIFE | 800-GET-MET8 | www.metlife.com

Benefit Resource Center
We're here to help!

Did your telephone call to your insurance carrier leave you more confused? The Benefit Resource Center (BRC) can help you understand what your insurance company is telling you.

A claim not paying? Has the insurance company told you that the claim is in process for the last two months? Call the BRC! We can work with the insurance carrier to identify the reasons why the claim is not processing and work to get it paid.

The BRC can also assist with benefit clarification. We can answer questions like: "Do I have mail order prescription benefits?" "How are physicals covered on my plan?" Call a Benefit Specialist. We'd be happy to answer these questions for you!

Services denied? The Benefit Resource Center is here to help. Our experience has allowed us to become well versed in writing appeal letters. Give us a call. We'll draft the appeal letter for you and submit it to the insurance company on your behalf.

Benefit Resource Center South

Toll free: 855.874.0835

BRCSouth@usi.com

Jay Dover

Investment Advisor Representative

Lincoln Financial Advisors®
A member of Lincoln Financial Group

Lincoln Financial Advisors
1170 Brookhaven Woods Ct.
Brookhaven, GA 30319
Phone: (678) 949-9277
Fax: (678) 949-9408
Email: Jay.Dover@LFG.com

Contact our Lincoln Financial Representative, Jay Dover, in order to sign up for participation in our 403(b) and 457 plans at Drew.

Lincoln Financial Group
You're In Charge

RETIREMENT PLAN SERVICES

Understanding your 403(b) plan

Planning Ahead series

Save today for a more confident tomorrow.

You recognize the importance of saving for your future. Enrolling in your retirement plan is a smart decision—and we're here to help you plan ahead, with information for every step along your journey to retirement.

Q&A Know the basics

What's a 403(b) plan?

A 403(b) plan is a tax-deferred retirement plan designed to help you invest regularly for your retirement. Your contributions are taken directly from your salary before it's taxed and can be invested among a selection of investment options.

Why should I consider a 403(b) plan?

It's a great way to save for retirement:

- **It's easy!** – You contribute through convenient automatic payroll deductions.
- **Tax-deferred growth** – You don't pay taxes on your contributions and earnings until you withdraw them, which leaves more money in the plan to provide greater growth potential.
- **Consistent savings** – Saving a set amount every payday can help you build the savings you need.
- **"Free" money** – Your employer may match all or a portion of your contributions.

When should I start contributing to the plan?

Today! The earlier you start saving, the longer your money has to grow. Beginning to save even one year earlier can make a difference.

The advantage of enrolling one year earlier

Securities and investment advisory services offered through Lincoln Financial Advisors Corp., a broker/dealer (Member SIPC)and registered investment advisor. Insurance offered through Lincoln affiliates and other fine companies. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

CRN-928350-051914

Drew Charter School 2019 Retiree Coverage

Drew Charter School

Are you planning on retiring from Drew Charter School soon? If so, we have options for you!

Once an employee terminates/retires, our Employee Benefits Partner, USI Insurance Services, will help coordinate one of these three options:

1. You may continue with your current Medical, Dental and Vision coverage under COBRA for 18 months (or up to 29 months if employee is disabled). Once you terminate, you will receive a COBRA notice from our COBRA vendor notifying you of the plans you are eligible to continue and the premiums for these plans.
You will work directly with our COBRA vendor to continue coverage under COBRA.

2. Once COBRA is exhausted, USI has an individual/family Insurance Partner that will coordinate your transition to personal insurance through the Exchange, where there may be extensive subsidies to offset your premiums, or through an individual plan outside of the Exchange.

3. Once a former employee attains age 65, USI's Medicare Consultants will assist in the transition to Medicare Part A and B with Medicare subsidies.

To explore either of these options, you may reach out to USI's Insurance Partners, Bert Hene or contact USI's My Benefit Advisor.

Inside of Georgia:
Bert Hene
678-384-3000
bert@henehealthbrokerage.com

Inside or Outside of Georgia:
www.mybenefitadvisor.com/usi

You have options, and we are here to help!

Important Legal Notices Affecting Your Health Plan Coverage

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.

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.

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 $149 per day (up to a $1,496 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.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Tanya Shannon
300 Eva Davis Way SE
Atlanta, Georgia 30317
470-355-1216
tanya.shannon@drewcharterschool.org

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.

Important Notice from Drew Charter School About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Drew Charter School 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. **Drew Charter School has determined that the prescription drug coverage offered by the Cigna Medical Plan Option 1, 2 & 3 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 15thto 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 Drew Charter School coverage will not be affected. You can keep this coverage and it will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Drew Charter School coverage, be aware that you and your dependents will be able to get this coverage back (during open enrollment or in the case of a special enrollment opportunity).

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 Drew Charter School 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 Drew Charter School 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:	July 1, 2019
Name of Entity/Sender:	Drew Charter School
Contact--Position/Office:	Tanya Shannon
Address:	300 Eva Davis Way SE, Atlanta, GA. 30317
Phone Number:	470-355-1216

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, 2019. 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/default.aspx	Website: http://dch.georgia.gov/medicaid 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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
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.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
	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, 2019, 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 12/31/2019)

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.

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: Drew Charter School	4. Employer Identification Number (EIN) 58-2528098	
5. Employer address: 300 Eva Davis Way SE.	6. Employer phone number: 470-355-1216	
7. City Atlanta	8. State Georgia	9. ZIP code 30317
10. Who can we contact about employee health coverage at this job? Tanya Shannon		
11. Phone number (if different from above)	12. Email address tanya.shannon@dewcharterschool.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:

    Fulltime employees working a minimum of 30 hours per week
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Legally married spouse, same and opposite sex domestic partners, 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)

Prepared on behalf of Drew Charter School by USI Insurance Services

This brochure summarizes the benefit plans that are available to Client Name eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.