LEGACY
TRADITIONAL SCHOOLS

2021-2022 EMPLOYEE BENEFITS
ARIZONA

OVERVIEW

Dear Valued Team Member,

At Legacy, families - and their choices - come first. Your choice to work for Legacy Traditional Schools, and entrust your family in our care, is something we recognize and value. It is in this spirit that we are pleased to present you with a comprehensive package of benefits to support you and your family's health choices.

We encourage you to take the time to review all the benefit options available to determine the best choices for your family. Additionally, we hope we have made the information easy and transparent within this guide to also assist in the process. As you flip through this guide, keep in mind the unique situation of your own family so you can best select the benefits that will meet you and your family's health needs.

We are also proud to have kept your cost for benefits low while maintaining the level of coverage. Your benefits are a key part of your overall compensation and we are committed to offering options that enhance your health while limiting the impact to your wallet.

Furthermore, as you review the many benefit options available, we hope you feel inspired to consider ways both you and your family can live a healthy lifestyle that promotes overall wellness, including physical, mental and financial health. By choosing to reflect on your wellness, you are also supporting our focus on family and the notion that we all have choices in our lives!

Ultimately, as a valued member of the team, we are committed to taking care of both you and your family. By providing options that support you and your family's health and wellness goals, we can all continue to achieve our pledge of changing lives through education.

Thank you for your ongoing dedication to Legacy Traditional Schools.

Sincerely,

Jason Fernandez

Jason Fernandez

VP of Human Resources

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CONTACTS

Employee Resources

Medical
Blue Cross Blue Shield of AZ (BCBSAZ)
Group/Policy: 31574
602-864-4400
www.azblue.com

Telemedicine
BlueCare Anywhere
www.bluecareanywhereaz.com

Health Savings Accounts (HSA)
HealthEquity
866-346-5800
www.healthequity.com

Flexible Spending Accounts (FSA)
HealthEquity
866-346-5800
www.healthequity.com

Dental
Ameritas
Group/Policy: 350871
800-487-5553
www.ameritas.com

Vision
EyeMed
Group/Policy: 1017233
866-939-3633
www.eyemed.com

Life and Voluntary Life
UNUM
Group/Policy: 00526892
866-679-3050
www.UNUM.com

Hospital Indemnity & Critical Illness
UNUM
Group/Policy: 00526892
866-679-3050
www.UNUM.com

Short and Long-Term Disability
UNUM
Policy ID: 00526892
866-779-1054
www.UNUM.com

401(k)
Empower
Plan Number: 86389-1-1
800-743-5274
www.retiresmart.com

Employee Assistance Plan
SupportLinc
Group/Policy: 01780
888-881-5462
www.supportlinc.com
Passcode: legacy

Legacy Traditional Schools
Employee Bene its Helpline
480-270-5438 ext. 4

This is an overview of your benefit options. The complete provisions of the plans are set forth in the plan documents. If the information in this overview is inconsistent with the plan documents, the plan documents will govern. This overview is not intended as a contract of employment or a guarantee of current, past or future employment. The plan sponsor(s) reserve the right to amend or terminate each plan at any time.

ELIGIBILITY & ENROLLMENT

Who is Eligible

1. Full-time Employees (working 30+ hours per week)

Eligible on the first day of the month coincident with/or following 30 days of employment:

- Medical
- HSA
- FSA
- Dental
- Vision
- Life & Disability
- 401(k) Retirement Plan

Employees will have 31 days to enroll from hire date.

2. Dependents

- Your legally married spouse (note that common law spouses are not eligible)
- Your dependent children up to age 26 (regardless of marital status), including a natural child, stepchild, legally adopted child, a child placed for adoption or a child for whom you or your spouse are the legal guardian.

Dependent Information for Enrollment

Legacy Traditional Schools is required by Medicare legislation to collect Social Security Numbers for your enrolled dependents. When enrolling or renewing your coverage, please have this information with you. Please submit Social Security Numbers for newborns once they are issued.

When to Enroll

Annual Open Enrollment

Legacy Traditional Schools' Open Enrollment will held annually during the Spring. This is the time for employees to re-evaluate their needs and elect benefit options for the new plan year.

Between Enrollment Periods

You may make changes to your benefit elections outside of the annual open enrollment ONLY if you experience a **Qualifying Life Event**, as defined by the IRS. Benefit changes must also be consistent with the qualified event.

Qualifying Life Events

Change in legal marital status:

- Marriage
- Divorce, legal separation, or annulment
- Death of your spouse

Change in the number of eligible children:

- Birth, adoption or death of child
- Child gains or loses eligibility for coverage under the plan

Change in benefits eligibility:

- A change in work status that causes you to gain or lose eligibility

Change in a family member's benefits eligibility or coverage under another employer's plans:

- A change in work schedule or status that causes him or her to gain or lose eligibility
- New coverage choices made during his or her employer's annual enrollment
- You or your family member's COBRA coverage from another employer expires
- You or your family member becomes eligible for or loses Medicare or Medicaid

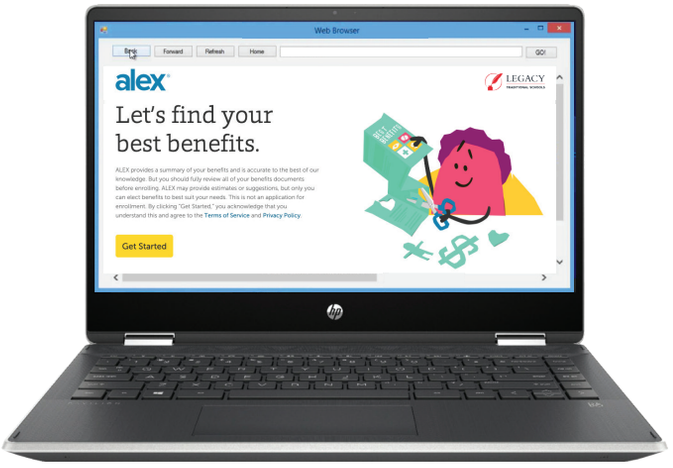
HOW TO ENROLL

Step 1 - Ask Alex

Everyone's benefits enrollment will begin by asking Alex. Designed to help you make smarter enrollment decisions, Alex will ask you a series of questions while guiding you through all of our major benefit options.

Upon completion, Alex will provide you with a set of recommendations you can print out and use in the next step of the enrollment process. To access Alex, simply visit: www.myalex.com/Legacy-Traditional-Schools/20212022

First, find your benefits...

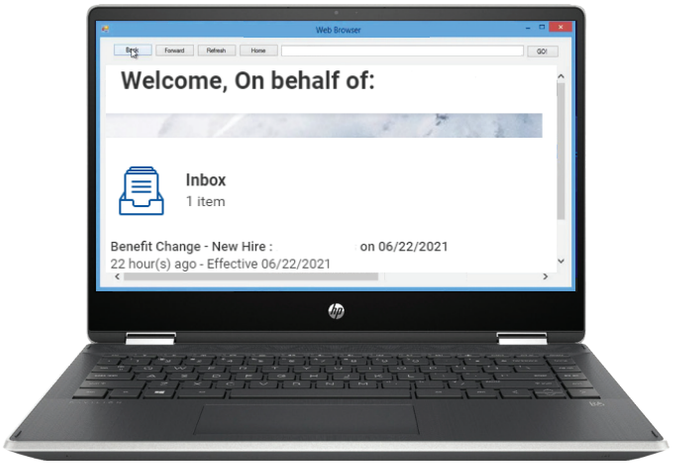


Step 2 - Enroll in Benefits Through Workday

Log in to Workday at www.myworkday.com/wday/authgwy/vertexeducation/login.html to get started with your benefit elections. In your Inbox, select the Benefit Change - New Hire message to start your enrollment.

Use the recommendations provided from Alex to make your benefit selections.

...Then complete your enrollment in Workday.



Step 3 - After You Enroll

Print a copy of your Benefit Confirmation after making your coverage selections. Review it thoroughly to ensure that your benefit elections have been recorded correctly.

If there are any errors, contact the Benefits Department immediately. Errors that are not reported by the end of the enrollment period cannot be corrected. Your next opportunity to make changes will be during the next annual open enrollment or within 30 days of experiencing a Qualifying Life Event.

Technical Issues?

If you experience any technical issues, you may find a solution in Zendesk. And, if you're unable to find what you're looking for in the Workday area, you can submit a ticket.

MEDICAL COVERAGE

Preventive Care

All medical plan options provide 100% preventive care coverage (subject to nationally-recognized age and gender guidelines) when services are performed by an In-Network provider. Preventive care can help your healthcare providers identify certain illnesses early and help prevent costly medical bills in the future. Preventive care services include:

- Annual preventive exam (physical)
- Screenings for blood pressure, cholesterol, colorectal cancer, diabetes (Type 2)
- Screenings for HIV (for everyone ages 15 to 65, and other ages at increased risk)
- Immunization vaccines
- Sexually Transmitted Infection (STI) prevention counseling and syphilis screening for adults at higher risk
- Well Child Care
- Women's and men's preventive services

When to Visit Urgent Care

Urgent care is the ideal solution for anyone requiring non-emergency care outside of office hours. Urgent care centers are far cheaper than emergency rooms, typically have shorter wait times, and are almost always more conveniently located. An urgent care center may be appropriate for conditions such as:

- Allergies
- Bronchitis
- Colds and flu
- Ear infections
- Minor burns & cuts
- Sore throat
- Sprains & Strains
- Upper respiratory illness
- Upset stomach
- Other common non life-threatening illnesses

When you are not sure where you should go for treatment, (if enrolled in a medical plan) call the BCBSAZ Nurse Line at 866-422-2729 for direction.

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Telemedicine - BlueCare Anywhere

One of the key benefits of BlueCare Anywhere is convenience. Virtual visits are available 24/7 and can be conducted anywhere you have access to a mobile device, tablet or computer with internet access, using these simple steps:

1. SIGN UP

It's simple and only requires name, email and password.

2. ENTER YOUR HEALTH DATA

and insurance information (first visit only)

3. CHOOSE A PHARMACY

in case medication is required

4. SEE THE DOCTOR

or schedule an appointment

5. AFTER THE VISIT, GET A SUMMARY

that you can share with your primary care provider

Care is available now. Set up your account by visiting www.bluecareanywhereaz.com or download the mobile app from the app store.

24/7 Nurse Line

With BCBSAZ, you have access to the 24/7 Nurse Line whenever you have symptoms or health care concerns, even in the middle of the night. Registered nurses, who have an average of 15 years of clinical experience, are available 24 hours a day, seven days a week to help you whenever you need health care advice.

CALL 866-422-2729

When you call, a registered nurse can help you:

- Understand a wide range of symptoms
- Determine if the Emergency Room, a doctor visit, or self-care is right for your needs
- Learn more about diagnosis
- Explore the risks, benefits and possible outcomes of treatment options
- Get tips on how nutrition and exercise can help you maintain a healthy weight
- Learn about important health screenings and immunizations

Did You Know?

All employees can access these programs at **$10 copy** when enrolled in one of the BCBSAZ medical plan options.

MEDICAL COVERAGE

This Year's Medical Plan Options

We are pleased to offer quality BCBSAZ health insurance plans which emphasize the prevention of disease, while providing comprehensive coverage for major medical conditions. An overview of the plans is provided below, however you can find more detailed information in the Summary of Benefits and Coverages (SBC) linked below.

VIEW THE SBC HERE

Medical Options	PPO $2,500		Alliance PPO $3,000* (Maricopa County only)	
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible				
Individual	$2,500	$6,000	$3,000	$6,000
Family	$5,000	$12,000	$6,000	$12,000
Out-of-Pocket Maximum				
Individual	$5,000	$7,500	$6,350	$12,700
Family	$10,000	$15,000	$12,700	$25,400
Coinsurance (Plan Pays)	80%	50%	80%	50%
Other Covered Services				
PCP/Specialist	$30 / $60 copay	50% AD	$25 / $45 copay	50% AD
Laboratory/X-ray	80% AD	50% AD	80% AD	50% AD
Advanced Imaging (CT, MRI, PET)	80% AD	50% AD	80% AD	50% AD
Preventive Care	100% covered	50% AD	100% covered	50% AD
Urgent Care	$50 copay	50% AD	$60 copay	50% AD
Emergency Room	$250 copay		$300 copay	
Hospital Services				
Inpatient	80% AD	50% AD	80% AD	50% AD
Outpatient	80% AD	50% AD	80% AD	50% AD
OptumRx Prescription Drugs*	Copay(s)		Copay(s)	
Retail (30 day supply) Level 1/Level 2/Level 3/Level 4	$10 / $35 / $60 / NA	Copay + balance bill	$15 / $45 / $75 / $130	Copay + balance bill
Specialty	$50 / $100 $150 / $200	Not Covered	$60 / $110 $160 / $210	Not Covered
Mail Order (90 day supply)	2x copay	Not Covered	2x copay	Not Covered
Employee Contribution Rates - Per Pay Period				
Employee	$122.00		$55.00	
Employee + Spouse	$440.00		$315.50	
Employee + Child(ren)	$310.00		$184.00	
Employee + Family	$548.00		$351.00	

AD = After deductible
*The Alliance Network is more limited but includes Banner Health and Honor Health and is only available in Maricopa County, AZ.

MEDICAL COVERAGE

The High-Deductible Health Plans (HDHP) have a deductible and an account to help you offset that deductible. That account, referred to as a health savings account (HSA), receives a contribution from Legacy Traditional Schools and can receive pre-tax contributions from you as well.

After your deductible is met under these plans, you'll pay a portion of the expenses through coinsurance until you reach the out-of-pocket maximum. An overview of the plans is provided below, however you can find more detailed information in the Summary of Benefits and Coverages (SBC) linked below.

VIEW THE SBC HERE

Medical Options	**HDHP/HSA $4,000**		**Alliance HDHP/HSA $4,000*** (Maricopa County only)	
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible Individual Family	 $4,000 $8,000	 $7,500 $15,000	 $4,000 $8,000	 $7,500 $15,000
Out-of-Pocket Maximum Individual Family	 $6,000 $12,000	 $10,000 $20,000	 $6,000 $12,000	 $10,000 $20,000
Coinsurance (Plan Pays)	80%	50%	80%	50%
Other Covered Services PCP/Specialist Laboratory/X-ray Advanced Imaging (CT, MRI, PET)	 80% AD 80% AD 80% AD	 50% AD 50% AD 50% AD	 80% AD 80% AD 80% AD	 50% AD 50% AD 50% AD
Preventive Care	100% covered	50% AD	100% covered	50% AD
Urgent Care	80% AD	50% AD	80% AD	50% AD
Emergency Room	80% AD		80% AD	
Hospital Services Inpatient Outpatient	 80% AD 80% AD	 50% AD 50% AD	 80% AD 80% AD	 50% AD 50% AD
OptumRx Prescription Drugs	After Medical Deductible		After Medical Deductible	
Retail (30 day supply) Level 1/Level 2/Level 3	$5/$15/$25 copay	50% AD	$5/$15/$25 copay	50% AD
Specialty	$50/$100 $150/$200 copay	Not Covered	$50/$100 $150/$200 copay	Not Covered
Mail Order (90 day supply)	2x copay	Not Covered	2x copay	Not Covered
Employee Contribution Rates - Per Pay Period				
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$60.00 $342.50 $200.00 $380.00		$25.00 $200.00 $102.00 $212.50	

AD = After deductible
*The Alliance Network is more limited but includes Banner Health and Honor Health and is only available in Maricopa County, AZ.

HEALTH SAVINGS ACCOUNT

Health Savings Account (HSA)

Legacy Traditional Schools offers a Health Savings Account (HSA) through HealthEquity. The HSA is a convenient way to save money on a pre-tax basis by contributing to a bank account to cover health related expenses such as: deductibles, coinsurance, out-of-pocket dental and vision expenses, prescription drugs, and more. The HSA cannot be used for cosmetic procedures, cosmetic prescriptions, or over-the-counter medications. The HSA is a true bank account, so you can only spend what you have accrued in the account.

Eligibility

You can only participate in the employer sponsored HSA if you are enrolled in a qualified High-Deductible Health Plan — through Legacy Traditional Schools.

You can't participate in the HSA if:

- You are covered under another plan that is not considered a High Deductible Health Plan that meets the minimum deductible of $1,400 for single coverage or $2,800 for family coverage
- You are enrolled in Medicare
- You are claimed as a dependent on someone else's taxes
- You or your spouse is enrolled in a Health Care Flexible Spending Account

You have to stop contributing to your HSA once you enroll in Medicare Part A and/or Part B, which happens at age 65 for most people. But, your HSA can continue to provide benefits long after you enroll in Medicare!

2021 Maximum Calendar Year HSA Contribution

(including the Legacy Traditional Schools contributions)

- Individual coverage: $3,600/year
- Family coverage: $7,200/year (2 people or more)
- $1,000 Catch Up contributions for those over the age 55

Employer Per Paycheck Contribution

Alliance HDHP/HSA $4,000 Plan

- Employee: $25.00
- Employee + Spouse: $45.83
- Employee + Child(ren): $58.33
- Employee + Family: $58.33

HDHP/HSA $4,000 Plan

- Employee: $25.00
- Employee + Spouse: $45.83
- Employee + Child(ren): $58.33
- Employee + Family: $58.33

LEGACY TRADITIONAL SCHOOLS

FLEXIBLE SPENDING ACCOUNTS (FSA)

Flexible Spending Accounts

An FSA allows you to set aside a portion of your salary, before taxes, to pay for qualified medical or dependent care expenses. Because that portion of your income is not taxed, you end up with more money in your pocket.

The Flexible Spending Accounts through HealthEquity run on a calendar year basis.

Healthcare Flexible Spending Account (FSA)

A Healthcare FSA allows you to budget and save for qualified medical expenses incurred over the course of your upcoming calendar year. It is a great savings tool for you and your family. The expense must be primarily to alleviate or prevent a physical or mental defect or illness and cannot be reimbursed by insurance or any other source. Your entire election amount is available the first day of your calendar year.

Eligible Expenses:

- Prescription medicines and drugs
- Orthopedic goods and prosthetic devices
- Doctors
- Dentists and orthodontics
- Chiropractors
- Optometrists, ophthalmologists, opticians, eyeglasses
- Over-the-counter medicines and drugs
- Medical services and health practitioners

Eligible Expenses:

- Cosmetic procedures or products
- Premiums paid for insurance coverage
- Gym memberships
- Infertility treatments
- Experimental or homeopathic treatments and vitamins

"Use It or Lose It" Rule

Both health and dependent care FSAs fall under the "Use it or Lose it" provision, as defined by the IRS. At the end of the plan year, unused funds will be forfeited. It is important to carefully estimate what your eligible health or dependent care expenses will be for the coming year, and be sure not to contribute more than that amount to your FSA.

You are required to enroll to participate and can then set aside up to $2,750 annually for any eligible medical care expenses. All claims incurred by June 30, 2022 can be reimbursed up to September 30, 2022. Unused Healthcare FSA funds do not carryover to the new calendar year and no refunds are provided for unused dollars.

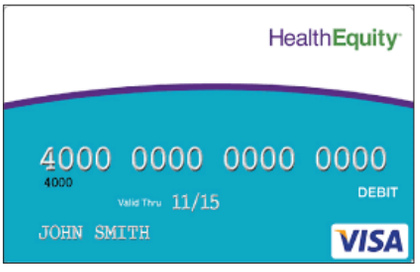
A Tax Savings Example	Without FSA	With FSA
Gross Monthly Salary	$3,000	$3,000
Pre-tax Contribution to FSA	$0	$-300
Taxable Salary	$3,000	$2,700
Less: FICA & Federal Tax	$-600	$-540
Take Home Pay	$2,400	$2,160
After Tax Health Expenses	$-300	$0
Net Take Home Pay	$2,100	$2,160
Increase in Monthly Spendable Income	$0	$60
Increase in Annual Spendable Income	$0	$720

Dependent Care Account (DCA)

A Dependent Care Account is a simple way to save money on care for your dependents. It allows you to set aside pre-tax dollars to pay for day care expenses. The annual IRS limit for this type of account is $5,000. If you are married and file separate returns, you can each elect $2,500 for the calendar year. To be eligible for this type of account, both you and your spouse (if applicable) must work, be looking for work or be full-time students. You may receive reimbursement up to the current balance in your account at the time the request is made.

Eligible Dependents:

- Children under age 13 who are claimed as a dependent for tax purposes
- Disabled spouse or disabled dependent of any age



DENTAL COVERAGE

Dental Coverage

Legacy Traditional Schools offers two dental plans. The dental plans are offered through Ameritas, which provides you with the flexibility of a broad network of dental care providers as well as generous benefits towards diagnostic & preventive care, two routine dental cleanings per year, and even major services. Orthodontic services are also covered by the Buy-Up Plan.

Just like your medical plan, you will receive the greatest benefit when you use an In-Network dental provider. To find In-Network providers in your area, please visit www.ameritas.com or call 800-487-5553.

FINDING IN-NETWORK DENTAL PROVIDERS
Visit www.ameritas.com

- Click on "Find a Provider" at the top
- Click on "Dental" and then "Network Provider"
- Enter Zip Code and select "PPO Network"
- Click on "Search"

If you seek services from an out-of-network provider, your out-of-pocket costs may be much higher and providers may balance bill you the cost difference between their charge and the network fee.

Dental Option	Base Plan		Buy-Up Plan	
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible Individual Family	$50 per person No maximum		$50 per person No maximum	
Annual Benefit Maximum	$1,000 per covered person		$1,500 per covered person	
Deductible Waived for Routine Services	Yes		Yes	
Routine Services Exams, X-Rays, Cleanings, Fluoride Treatments, Space Maintainers	$10 copay, 100%		100%	80%
Basic Services Root Canals, Simple Extractions	50% after deductible		80% after deductible	50% after deductible
Major Services Crowns, Onlays, Inlays, Denture Repair	25% after deductible		50% after deductible	
Orthodontics (Adult & Child) Lifetime Maximum	Not Covered		50% $2,000 per covered person	
Employee Contribution Rates - Per Pay Period				
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$13.66 $25.62 $24.80 $37.10		$23.42 $44.52 $46.96 $69.66	

Coinsurance shown is what plan pays.

VISION COVERAGE

Vision Coverage

Legacy Traditional Schools vision plan, offered through EyeMed, provides you with the flexibility of a broad network of vision care providers as well as generous benefits towards vision care, eye-wear and contacts. The plan also offers discounts on laser vision correction.

An EyeMed eye doctor will check the health of your eyes and the quality of your vision. To find In-Network vision care providers in your area, please visit www.eyemed.com or call 866-939-3633.

FINDING IN-NETWORK VISION PROVIDERS
Visit www.eyemed.com

- Click on "Find a Provider"
- Enter your zip code and select the **Insight Network** from the drop down menu
- Click on "Get Results"

Note: You will receive an ID card in the mail upon enrollment. However, you do not need a member ID card to use your benefits. Simply give the vision provider your Social Security number.

Vision Option		
Benefits	In-Network	Out-of-Network
Benefit Frequencies Exam Lenses Frames Contacts	 Once every 12 months Once every 12 months Once every 12 months Once every 12 months	
Eye Exam	$10 copay	Up to $40 allowance
Lenses Single Bifocal Trifocal	 $25 copay $25 copay $25 copay	 Up to $30 allowance Up to $50 allowance Up to $70 allowance
Frames	$130 allowance + 20% off balance over $130	Up to $91 allowance
Contacts (in lieu of glasses) Medically Necessary Cosmetic (Elective)	 Covered in Full $130 allowance + 15% off balance over $130	 Up to $210 allowance Up to $130 allowance
Laser Vision Correction	15% off retail or 5% off promo price	N/A
Employee Contribution Rates - Per Pay Period		
Employee Employee + Spouse Employee + Child(ren) Employee + Family	Paid for by Legacy Traditional Schools if enrolled	

LIFE INSURANCE

Basic Term Life and AD&D

All active, full-time employees receive a company-paid Term Life/AD&D Insurance benefit provided by UNUM.

Basic Term Life and AD&D Coverage	
Employee	1x salary up to $100,000*

*The benefit is reduced to 65% at age 65 and 50% at age 70.

Optional Supplemental Life and AD&D

All benefit eligible employees may purchase optional life and AD&D coverage provided by UNUM, for themselves, their spouse, and dependent children. This coverage is portable and offers a Waiver of Premium.

Optional Life + AD&D: Available Coverage Amounts	
Employee	Increments of $10,000 up to $500,000 not to excess 5x BAE
Spouse	Increments of $5,000 up to maximum of $100,000, not to exceed employee's benefit amount
Child(ren) (to age 26)	Increments of $5,000 up to $20,000, not to exceed employee's benefit amount

BAE: Basic Annual Earnings

Guaranteed Issue Amounts*	
Employee	$150,000
Spouse	$30,000
Child(ren) (to age 26)	$20,000

*Newly eligible employees only

Evidence of Insurability (EOI) is required after your initial enrollment if you make an election of $10,000 or more for employee only.

EOI is always required for spouse enrollment.

Hospital Indemnity Insurance

Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth. The money is paid directly to you – not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as coinsurance, Copays and deductibles.

What's included?

- $1,500 for each covered hospital admission - once per year
- $200 for each day of your covered hospital stay, up to 60 days - once per year
- $400 for each day you spend in intensive care, up to 15 days - once per year
- $150 for emergency room treatment for a covered accident once per year
- $100 for ambulance or $500 for air ambulance transportation for a covered accident once per year

Why is this coverage so valuable?

- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.
- Wellness Benefit: Based on your plan, this benefit can pay $50 per calendar year per insured individual if a covered health screening test is performed, including: blood tests, chest X-rays, stress tests, mammograms, and colonoscopies
- A full list of covered tests will be provided in your certificate.

Critical Illness

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

What's covered?

- Heart attack
- Stroke
- Major organ failure
- End-stage kidney failure
- Coronary artery disease:
  Major (50%): Coronary artery bypass graft or valve replacement

  Minor (10%): Balloon angioplasty or stent placement

Who can get coverage?

Consult the table below to see coverage options:

Coverage Options	
Employee	Choose $10,000, $20,000 or $30,000 of coverage with no medical questions if you apply during this enrollment.
Spouse	Spouses can get 50% of the employee coverage amount as long as you have purchased coverage for yourself.
Child(ren) (to age 26)	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

EMPLOYEE ASSISTANCE PROGRAM

Employee Assistance Program (EAP)

The demands of everyday life don't stop when you go to work. Legacy Traditional Schools provides you and your family with benefits from SupportLinc's EAP, including:

This program can help with a range of work/life challenges pertaining to:

- Wellbeing & Mental Health
- Family Care and resources
- Career Workplace Tools and resources
- Lifestyle, Home Improvement & Pet Care
- Identity Theft Prevention and Recovery Assistance
- Child and Elder Care Referrals
- Daily Living Services
- Legal and Financial

BENEFITS INCLUDE:

- Phone access to an advocate who can connect you with community resources and online tools 24/7. For a consultation, please call 888-881-5462
- Up to six in-person sessions with a specialist, available to you and/or members of your household

SupportLinc Online Services

SupportLinc is a secure member website that helps you use your SupportLinc benefits efficiently and to your best advantage:

- Assessments: depression, alcoholism, insomnia, stress and more
- Self-help programs, articles and resources
- In-depth Health Risk Assessment
- Online Smoking Cessation Program
- Weight Loss and Nutrition Resources
- Download legal forms
- On-line Estate Planning

Website URL: **www.supportlinc.com**

Log-in online access code: **legacy**

Did You Know?

Your conversations with your EAP counselor are strictly confidential, and Legacy Traditional Schools never receives identifying information about who is using the EAP plan.

OTHER PERKS:

Complimentary cybersecurity for your home Mac or PC is now available through Sophos. Simply follow these steps:

1. Visit home.sophos.com/employee
2. Enter your work email for verification purposes
3. Follow the prompts to register your personal email for an account or upgrade your existing account

Your complimentary Sophos Home Commercial Use Edition includes malware scan and clean, real-time anti-virus, ransomware protection, and much more.

LEGACY TRADITIONAL SCHOOLS

DISABILITY

Short-Term Disability

In the event you become disabled from a non-work related injury or medical condition that leaves you unable to work for a short period of time, short-term disability benefits become a valuable source of income. This benefit, provided through UNUM, is designed to replace a portion of your paycheck. The premium for this benefit is paid 100% by Legacy Traditional Schools.

Short-Term Disability	
Benefits Begin	15th day of illness, maternity or off-the-job injury
Benefit Duration	11 weeks maximum
Benefit Amount	60% of your weekly salary, up to $2,000/week

Long-Term Disability

Long-Term disability insurance covers loss of income should you become unable to work as a result of illness or injury. Long-Term Disability coverage insures a paycheck and helps offset things such as your mortgage payment, utility bills, groceries for your family, etc. Long-Term disability benefits pick-up where your STD plan leaves off. The premium for this benefit is paid 100% by Legacy Traditional Schools.

WHAT IS "OWN OCCUPATION" COVERAGE?

An "own occupation" policy generally defines disability as the inability to perform the duties of one's own occupation. This is a more liberal definition of disability than the inability to work in any occupation whatsoever. Legacy Traditional Schools LTD plan is a "split definition" policy that, for two years, will partially replace income for employees who are unable to work in their own profession due to a disabling illness or injury. After two years, the policy will still cover you if you are unable to work at all, in any occupation.

Long-Term Disability	
Benefits Begin	91st day of illness or off-the-job injury
Benefit Duration	2 years own occupation then any occupation, up to Social Security normal retirement age
Benefit Amount	50% of your monthly salary, to a maximum of $6,000/month
Pre-existing Condition	3/12. Any condition treated 3 mos. prior to coverage start date will not be covered for the first 12 mos. Refer to policy for full details.

401(K) RETIREMENT

401(k) Retirement Plan

To help you build a solid financial future, Legacy Traditional Schools is proud to offer our eligible employees a 401(k) retirement plan through Empower.

MAXIMUM TAX-DEFERRED CONTRIBUTIONS:
Annual maximum contributions and "catch-ups" are dictated by Federal Laws. The maximum contribution amount was set at $19,500 in 2021. Catch-up contributions age 50 and older are set to $6,500.

ENROLLMENT PERIOD

- 1st day of the calendar month following 30 days of employment
- To enroll in the 401(k) Plan, go to www.retiresmart.com. Click on Create New Account. Legacy's 401(k) Plan Number is 86389.

MATCHING CONTRIBUTIONS
You can contribute up to 80% of your eligible earnings (no 1/2 percents allowed) and the company will match the first 6%, dollar-for-dollar.

VESTING SCHEDULE
Legacy Traditional Schools will continue to provide dollar for dollar matching contributions up to 6%, but the company match won't be available to you until you are fully vested, which is after three years of service. This means you will need to complete three years of service to receive 100% of the employer match contributions. Generally, a "year of service" for vesting is calculated on a 12-month basis and runs from July 1 through June 30.

Vesting Schedule	
Year 1	0
Year 2	0
Year 3	100

FREQUENTLY ASKED QUESTIONS

Who is eligible for coverage?
Active, full time employees working 30 or more hours per week and their eligible dependents.

When can I enroll for coverage?
Eligible employees can enroll during the annual open enrollment period and/or within 30 days of experiencing a Qualifying Life Event (QLE).

When will coverage begin?
Both employees and their dependents become eligible on the first day of the month coincident with/or following 30 days of employment.

What is open enrollment?
Open enrollment is the time each year that you can enroll and/or make changes to your elections. Open enrollment is the only time each year that you can make changes WITHOUT experiencing a QLE.

What if I miss the open enrollment period for benefits?
If you miss the open enrollment period, you will not be able to enroll or make changes until the next annual open enrollment period, unless you experience a QLE that permits you to make benefits changes under IRS rules.

How do I enroll?
All employees must make their elections online using the Workday enrollment site.

What if I do not want coverage?
If you choose to waive coverage, you must still log onto Workday and let us know you are declining coverage and the reason you are not interested.

When will I get my medical card?
Once you have made your benefit elections in Workday, it takes about two to three weeks to receive your ID cards. If you need to use services in the meantime, you can contact the benefits team. You will need to show your ID card when you visit a doctor or get a prescription filled.

What is a Qualifying Life Event?
Qualifying Life Events include, but are not limited to the following:

- Marriage, divorce, legal separation
- Birth or adoption of a child
- Death of a spouse or child
- Spouse's Open Enrollment
- Change in spouse's employment and/or insurance
- Other events may qualify (contact our Benefits Department for questions)

Who is an eligible dependent?
An eligible dependent is:

- Your legally married spouse (note that common law spouses are not eligible)
- Your dependent children up to age 26 (regardless of marital status), including a natural child, stepchild, legally adopted child, a child placed for adoption or a child for whom you or your spouse are the legal guardian.

When does health/benefits coverage end?
If you leave Legacy Traditional Schools (or Vertex), benefits end as follows:

- **Medical, dental, vision:** Last day of the month in which your last day of employment falls
- **Life insurance, disability, hospital insurance, critical illness:** Last day of employment

MEDICAL TERM GLOSSARY

Allowed Amount
Maximum amount on which payment is based for covered medical services. This may be called "eligible expense," "payment allowance" or "negotiated rate". If an Out-of-Network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing
When an out-of-network provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. In-Network providers cannot balance bill you for the covered services.

Coinsurance
Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe.

Copayment
A fixed amount which you pay at the time of service. Copays are most common for emergency room, urgent care and prescription drugs. In some cases you may be responsible for paying a copay as well as percentage of the remaining charges.

Deductible
The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service/test, per visit, per supply or per coverage year.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a healthcare provider for everyday or extended use. DME coverage may include oxygen equipment, wheelchairs or crutches.

Explanation of Benefits (EOB)
A record sent by your health plan that explains how much you owe. The EOB also shows the total cost of care, how much your plan paid and the amount an In-Network doctor or other healthcare professional is allowed to charge a BCBSAZ member (called the "allowed amount").

Health Savings Accounts (HSA)
Legacy Traditional Schools contributes money into an HSA for you to help offset some of your out-of-pocket costs. Employees can also contribute money into the HSA through pre-tax payroll deductions. This account is owned by the employee and funds roll over year after year. The account is also portable. If your employment with Legacy Traditional Schools ends, you take the account with you.

In-Network Coinsurance
The percent you pay of the allowed amount for covered medical services to providers who contract with our health insurance carrier. In-Network coinsurance costs you less than Out-of-Network coinsurance payments.

In-Network Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Using In-Network providers will cost you less money. When contacting an In-Network Provider, remember to ask "are you a contracted provider with my plan?" Never ask if a provider "takes" your insurance, as they will all take it. The key phrase is "contracted."

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

Network
The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower and you will not be responsible for filing claims if you visit a participating In-Network provider.

Out-of-Network Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Network Coinsurance
The percent you pay of the allowed amount for covered medical services to providers who do not contract with our health insurance carrier. Out-of-Network coinsurance costs you more than In-Network coinsurance. An Out-of-Network provider can balance bill you for charges over the allowed amount. (See Balance Billing.)

Out of Pocket Limit
The most you pay during a policy period (a calendar year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Preauthorization
A medically necessary determination by our health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Our plans may require preauthorization (also known as prior authorization, prior approval or precertification) for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Premium
The amount the employee contributes though payroll deductions that must be paid for your health insurance or plan.

Prescription Drug Coverage
Coverage that helps pay for prescription drugs and medications covered under BCBSAZ's formulary. A formulary is the list of FDA approved drugs covered under the medical plan. Each drug is classified into a tier, which determines the copayment you will pay for the drug. These tiers typically are: Level 1, Level 2 and Level 3.

- Level 1 - medication whose active ingredients, safety, dosage, quality and strength are identical to that of its Level 2 counterpart.
- Level 2 - generally do not have a Level 1 equivalent, while those listed as Level 3 name drugs generally do have a Level 1 or Level 2 equivalent.

Primary Care Physician
A physician who directly provides or coordinates a range of medical services for a patient. Primary Care Physicians include Medical Doctors, Doctors of Osteopathic Medicine, Internists, Family Practitioners, General Practitioners, and Pediatricians.

Provider
A physician, healthcare professional or healthcare facility, certified or accredited as required by state law.

Specialist
A physician specialist who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

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

Note, website addresses in this notices section are not hyperlinked. To visit any of these sites simply copy and paste the URL into your web browser. Phone numbers in this section also aren't activated. Simply dial the number directly using your phone.

HIPAA NOTICE OF PRIVACY PRACTICES

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

Our Company's Pledge to You
This notice is intended to inform you of the privacy practices followed by the Legacy Traditional Schools (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on July 1, 2021.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. The Plan requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information
Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information
Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law.
We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization.
When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

NOTICES

To the Plan Sponsor. We may disclose protected health information to certain employees of the Plan for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

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

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Vertex Education
For Legacy Traditional Schools
3125 S. Gilbert Rd.
Chandler, AZ 85286
480-270-5438, Option 4, Option 2

Complaints
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

This form does not constitute legal advice and is provided "as is." This form is based upon current federal law and is subject to change based upon changes in federal law or subsequent interpretive guidance. This form must be modified to reflect the user's privacy practices and its state law where the state law is more stringent.

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

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

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

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

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

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

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

For More Information or Assistance
To request special enrollment or obtain more information, please contact:

Vertex Education
For Legacy Traditional Schools
3125 S. Gilbert Rd.
Chandler, AZ 85286
480-270-5438, Option 4, Option 2

Note: If you and your eligible dependents enroll during a special enrollment period, as described above, you are not considered a late enrollee. Therefore, your group health plan may not require you to serve a pre-existing condition waiting period of more than 12 months. Any preexisting condition waiting period will be reduced by time served in a qualified plan.

IMPORTANT CREDITABLE COVERAGE NOTICE FROM LEGACY TRADITIONAL SCHOOLS 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 Legacy Traditional Schools 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.

NOTICES

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. Legacy Traditional Schools has determined that the prescription drug coverage offered by the BCBSAZ medical plans (PPO $2,500, Alliance PPO $3,000, HDHP/HSA $4,000 and Alliance HDHP/HSA $4,000) 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 Legacy Traditional Schools coverage may not be affected.

If you do decide to join a Medicare drug plan and drop your current Legacy Traditional Schools coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Legacy Traditional Schools 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 or call BCBSAZ Customer Service at 602-864-4400. 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 Legacy Traditional Schools 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).

7/31/21 through 6/30/22
Vertex Education
For Legacy Traditional Schools
3125 S. Gilbert Rd.
Chandler, AZ 85286
480-270-5438, Option 4, Option 2

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS **CONTINUATION COVERAGE RIGHTS UNDER COBRA**

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

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

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

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

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

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

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

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

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

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

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage.

NOTICES

Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

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

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

Plan Contact Information

Vertex Education
For Legacy Traditional Schools
3125 S. Gilbert Rd.
Chandler, AZ 85286
480-270-5438, Option 4, Option 2

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

WHAT IS THE AFFORDABLE CARE ACT?

The Affordable Care Act (ACA) is a comprehensive healthcare reform law enacted in March 2010. For plan years through 2020, if you can afford health insurance but choose not to buy it, you may pay a fee called the individual Shared Responsibility Payment. (The fee is sometimes called the "penalty," "fine," or "individual mandate"). Starting with the 2020 plan year (for which you'll file taxes in April 2020), the Shared Responsibility Payment may still apply in some states. If you don't have coverage during 2019, the fee no longer applies. You don't need an exemption in order to avoid the penalty. If you're 30 or older and want a "Catastrophic" health plan, you may want to apply for an exemption. See details about exemptions and catastrophic coverage at www.healthcare.gov. As an eligible employee, you may participate in the Legacy Traditional Schools medical plan(s).

Implications For You
Legacy Traditional Schools' health plan exceeds what is considered to be "acceptable coverage" as defined under the Patient Protection and Affordable Care Act. Because of this, should you decline coverage through Legacy Traditional Schools, you will not qualify for government credits and subsidies to purchase individual health insurance on the Federal government or State-run Marketplaces.

What this essentially means is that coverage obtained through one of the Marketplaces will most likely cost you considerably more than obtaining coverage through Legacy Traditional Schools, however you do have the option to enroll in other plans should you opt out of the Legacy Traditional Schools plan(s).

Options for obtaining coverage independently include the Federal and/or State marketplaces, private insurance brokers, insurance carriers, Medicare, Medicaid, and CHIP.

NOTICE OF THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

The health benefits of most plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient:

- all stages of reconstruction of the breast on which a mastectomy has been performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- breast 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. More information on WHCRA benefits is noted in the Medical Summary of Plan Information.

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).

NOTICES

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, 2021. Contact your State for more information on eligibility –

To see if any other states have added a premium assistance program since January 31, 2021, 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

ALABAMA – Medicaid

Website: http://myalhipp.com
Phone: 1-855-692-5447

ALASKA – 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

ARKANSAS – Medicaid

Website: http://myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: ttps://dhs.iowa.gov/ime/members/medicaid-a-to-z/hip
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

LEGACY TRADITIONAL SCHOOLS

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com
Toll-free Phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137. OMB Control Number 1210-0137 (expires 1/31/2023)

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844-606-3331

Employee Benefits Helpline