2024 - 2025

Full Time Employees Benefits Guide

North America Central School Bus

Table of Contents

NACSB'S Employee Benefits Program

Welcome

Welcome to North America Central School Bus's benefits guide for the 2024-25 plan year. This guide provides basic information about NACSB's full-time employee benefits and what you need to do if you would like to enroll in benefits for the 2024-25 plan year. Please review this guide carefully so you understand the various benefit programs being offered and their costs before you make your elections.

Once you make your elections you cannot drop or change coverage, outside of open enrollment, unless you have a qualifying life event (QLE).

All benefit elections from the prior year (except pre-tax contributions*) will remain the same unless you make a change during your open enrollment window.

***You will need to re-elect any HSA and FSA contributions every year, these elections do not carry over automatically**

CORE BENEFIT PLAN

- Medical coverage – 4 plan options
- Dental coverage – PPO
- Vision coverage
- Life & Disability
- and more!

DISCLAIMER:

This brochure is intended as a brief summary of the benefits available to eligible full-time employees of North America Central School Bus. Please refer to the carrier materials and summary plan description for further details. Should there be a conflict between this communication and the carrier materials/summary plan description, the carrier materials and summary plan description will prevail.

Enrollment & Eligibility

HOW TO ENROLL

This year, you will enroll through the Dayforce enrollment platform. Please be on the lookout for a communication from HR regarding your enrollment options.

To enroll:

- Log into Dayforce
- Select the “Benefits” tab from the main menu.
- Click the “Start Enrollment” button on the right side of the page
- Follow the enrollment instructions on the portal

Remember, once you make your selection, you may not change your benefits during the year until the next Open Enrollment period unless you have a qualifying life status change.

Qualifying life status changes include:

- Marriage or Divorce
- Birth or adoption of your child
- Death of your spouse or your child
- Change in your child’s dependent status
- Change in your spouse’s employment status
- Change in your benefit eligibility status

GENERAL ELIGIBILITY INFORMATION

Newly hired NACSB employees are eligible for benefits on the 1st of the month following 30 days of employment; however, you can enroll in benefits at the following times throughout your employment:

- When you are first hired - within the first 30 days
- When you are newly eligible
- During the annual Open Enrollment period
- If you experience a qualified life event or status change

Who is Eligible for coverage?

- Regular, full time hourly and salaried employees of NACSB
- Your lawful spouse
- Dependent children up to age 26, regardless of student status
- Children aged 26 or older who are physically or mentally disabled and rely on you for at least 50% of their support

*Children and spouses of your eligible children are not eligible for coverage

Medical Plan Overview

North America Central School Bus offers four medical plans through Blue Cross Blue Shield of Illinois (BCBSIL). Below is a chart to help you identify which type of plan may fit your needs.

Please note: the Blue Advantage HMO is available to Illinois residents only.

If you enroll in the BlueEdge HSA Plan, NACSB will contribute $50/month for Single or $100/month for EE+ coverage into the Health Savings Account you open through HSA Bank. Contributions you make to the HSA Bank Health Savings Account can be made on a pre-tax basis through payroll deductions. An HSA payroll deduction form will be made available to you after enrollment into the HSA Plan.

BCBS of Illinois®

PPO: (800) 541-2768
HMO IL: (800) 892-2803
bcbsil.com

Medical Coverage

Plan Feature			Blueprint PPO	Value Choice PPO	Blue Edge HSA	Blue Advantage HMO
Deductible	In-Network	Single	$1,000	$2,500	$3,200	$0
		Family	$3,000	$7,500	$6,400	$0
	Out of Network	Single	$2,000	$5,000	$6,400	Not Covered
		Family	$6,000	$15,000	$12,800	Not Covered
Out-of-pocket Maximum (Includes deductibles)	In-Network	Single	$3,000	$5,000	$6,200	$1,500
		Family	$9,000	$12,700	$12,400	$3,000
	Out of Network	Single	$6,000	$10,000	$18,600	Not Covered
		Family	$18,000	$25,400	$37,200	Not Covered
Rx Out of Pocket Maximum	In-Network and Out of Network	Single	$1,000	Included in Medical Out of Pocket Maximum	Included in Medical Out of Pocket Maximum	$1,000
		Family	$3,000			$3,000
Coinsurance	In-Network		20% after deductible	20% after deductible	20% after deductible	0%
	Out of Network		40% after deductible	40% after deductible	40% after deductible	Not Covered
In-Network Office Visit	PCP Copay		$30	20% after deductible	20% after deductible	$30
	Specialist Copay		$50			$50
Other Copays	ER		$150	$150	10% after deductible	$150
	IP Hospital		20% coinsurance	20% coinsurance	20% after deductible	0%
Pharmacy Copays (30 Day Retail)	Generic		$15	20% after deductible	30% after deductible	$15
	Preferred		$30			$30
	Non-Preferred		$50			$50
Availability			all states	all states	all states	**IL ONLY**

BCBS made changes for the 2024-2025 to the deductible and out-of-pocket limits for the BlueEdge HSA plan. Those changes are highlighted in red in the above table.

Note of deductibles and out-of-pocket maximums: Any dollars that you accumulate toward the deductible and out-of-pocket maximums will reset on a calendar year basis. If you switch plans, the accumulator will transfer over to the new plan.

Medical Bi-Weekly Rates (Per Paycheck)

Coverage Tier	Blueprint PPO	Value Choice PPO	BlueEdge HSA	Blue Advantage HMO
Employee Only	$264.47	$103.01	$147.64	$243.19
Employee + Spouse	$543.62	$288.07	$303.71	$499.71
Employee + Child(ren)	$384.84	$187.63	$225.87	$358.63
Family	$661.43	$311.96	$355.06	$612.80

Medical Plan Designs

MORE ABOUT THE BLUE EDGE HSA PLAN

BlueEdge HSA is a consumer-directed plan that lets you decide how, when and where your healthcare dollars are spent. BlueEdge HSA combines a PPO plan with a tax-free Health Savings Account (HSA) to help cover the health care expenses you pay out of pocket, such as copayments and deductibles.

About Health Savings Accounts

There are IRS guidelines that limit how much may be contributed to an HSA each year. These limits are outlined below for 2024.

Calendar Year	2024
Annual Contribution Maximum	$4,150 Single/$8,300 Family
Annual Catch-up Maximum	Additional $1,000 (for HSA eligible individuals aged 55 or older)

The maximum amount you can contribute is inclusive of amounts that may be contributed by North America Central School Bus. The total combined amount deposited into your HSA bank account, by you and the company, may not exceed the above IRS yearly maximum.

What you need to do if you enroll in the BlueEdge HSA Plan:

- Complete the enrollment application and return to the home office with the BlueEdge HSA as your plan choice
- Watch for information to come in the mail from HSA Bank
- Provide your signature to activate your account
- Decide how much you wish to contribute to your HSA
- Begin funding your HSA through automatic payroll deductions
- Receive and begin using your HSA checks and HSA debit card
- Watch your savings grow online at Blue Access for Members

A few more important points about Health Savings Accounts:

- The money in your account is yours to keep (account balances roll over every year)
- You can use the money to pay for eligible expenses (deductibles, prescription drugs, doctor's office visits, etc.) on a tax-free basis
- If you use the money in the account for anything other than eligible medical expenses, you will be taxed on that amount
- You must be enrolled in a qualified high deductible health plan in order to open a health savings account as well as be able to make contributions every year

Finding a Participating Provider

Remember you will receive the greatest benefit if you utilize in-network providers. Always check with your doctor to be sure he/she is a participating provider. You can also find BCBS participating physicians and hospitals at **www.bcbsil.com** or by calling Member services at:

· HMO: 800-892-2803

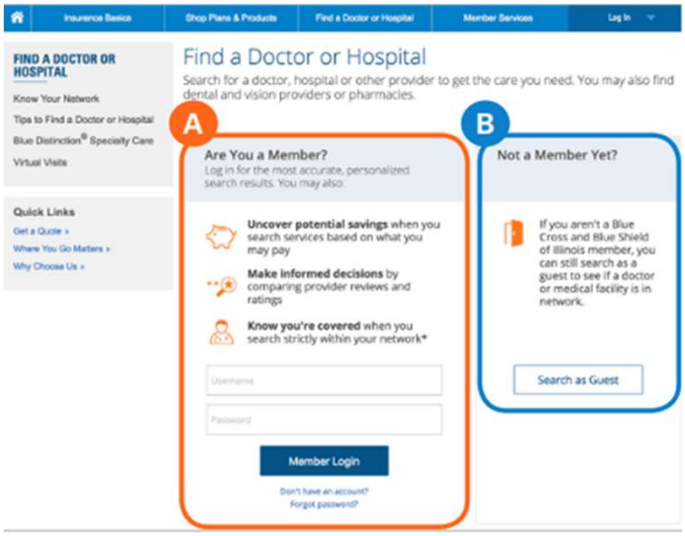
· PPO: 800-541-2767

FIND A DOCTOR OR HOSPITAL WITH PROVIDER FINDER

Visit **www.bcbsil.com**

Click Find a Network Provider and complete the questions below. If you are not a member yet, you can search as a guest from the home page.

- How do you get insurance? **Through my employer or my spouse's employer.**
- Are you a member or are you shopping for an insurance plan? **I am a member.**
- Select the type of care you are looking for: **Medical**
- Where do you live?
- Select the plan that you are enrolled in, or would like to enroll in:
    - **Blue Advantage HMO (Illinois Residents Only)**
    - **BluePrint PPO**
    - **Value Choice PPO**
    - **BlueEdge HSA**



IMPORTANT INFORMATION ON THE BLUE ADVANTAGE HMO

- Only Illinois residents are eligible for the Blue Advantage HMO
- BCBS HMO group health insurance requires the designation of a primary care provider
- You have the right to designate any primary care provider who participates in the Blue Advantage HMO network and who is available to accept you or your family members
- For children, you may designate a pediatrician as a primary care provider
- You do not need prior authorization from BCBS or your primary care provider to obtain access to obstetrical or gynecological care professionals in the BCBS network
- Your health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or following procedures for making referrals

Flexible Spending Account (FSA)

ICSB's Health Flexible Spending Account (FSA) and Limited Purpose Flexible Spending Account (LPFSA) allow you to use tax-free dollars to reimburse yourself for a wide variety of health care expenses that aren't covered through your other benefit plans. The annual amount you elect to contribute to each account will be divided into equal amounts and deducted from your paycheck before federal and, in most cases, state and local income taxes are withdrawn.

Rules and Regulations

Plan your annual FSA contribution amounts carefully; the election you make when you enroll is binding for the entire plan year unless you have a qualifying status change. Additionally, the IRS imposes some rules and restrictions on the way you can use FSAs:

- You must incur eligible expenses during the plan year.
- ICSB offers a $610 carryover for Medical FSA which allows participants to roll over up to $610 from plan year to plan year.
- You can only make changes to your contribution amounts with a qualified status change. These include marriage, divorce or legal separation, death of a spouse or dependent, change from part-time to full-time or full-time to part-time employment, termination or commencement of spouse's employment, unpaid leave of absence, significant change in health coverage due to spouse's employment.

Health Care FSA

Healthcare expenses for yourself and your dependents – such as deductibles, coinsurance, copays–are eligible for reimbursement from your Health Care FSA. The maximum contribution is $3,200 for the 7/1/24 to 6/30/25 plan year.

How do I file a claim?

- Submit a claim online in the Chard-Snyder portal
- Submit a claim using the Chard-Snyder mobile app. You can download it for free* from your mobile app store. You will use the same username and password that you use for this website.
- Complete a paper claim form and mail or fax it with your documentation.

Limited Purpose FSA

A limited purpose FSA (LPFSA) is a flexible spending account that only reimburses you for eligible dental and vision expenses. A LPFSA is available to employees who are enrolled in an HSA. By establishing a LPFSA, you can save money on taxes by using your LPFSA dollars for your dental and vision expenses while preserving your HSA funds for other purposes, including simply saving those funds for the future. **LPFSAs only apply to members enrolled in the HSA medical plan**

Dental

The dental benefits are provided by MetLife Life Insurance Company. Please refer to the table below for a brief description of the dental benefits; full coverage details can be found in the dental certificate.

* For out-of-network services you will be responsible for the difference between your dentist's charge and the covered percentage of the Usual and Customary fee for a given service

MetLife Contact Information

800-GET-MET8

https://www.metlife.com/

MetLife PPO	In-Network	Non-Network
Network	PDP	
Primary Dentist/Referrals	Not Required	
Deductible (waived for preventive)		
Individual	$50	$100
Family	$150	$300
Annual Maximum	$1,250	
Preventive	100%	100% of usual and customary
Basic Services (Fillings, Root Canals, Inlays, Onlays, Extractions, Etc.)	80%	80% of usual and customary
Major Restorative (Dentures, Bridges, Implants)	50%	50% of usual and customary
Orthodontics	Not covered	

Frequencies	
Office Visits & Exams	Once every 6 months
X-Rays	Bitewing – once every 12 months
	Full Mouth – once every 60 months
Crown, Bridges	Replacement every 10 years*

Coverage Tier	Bi-weekly Contribution
Employee	$6.02
Employee + Spouse	$11.91
Employee + Children	$14.15
Family	$20.04

TELEDENTISTRY THROUGH MetLife

You are now able to use Teledentistry through your MetLife dental plan!

During your virtual visit, a dental care professional can help you:

- Determine if you have a serious condition that requires urgent treatment
- Suggest things you can do at home to relieve your symptoms
- Assess toothaches, infections, and provide prescription medications if needed
- Offer guidance and advice
- Refer you to a MetLife network dentist if further care is needed

1. Log in to your MyBenefits account at online.metlife.com. On both the Accounts page and the Find a Dentist page, you will find the "Start Virtual Visit" link.
2. Register or log in to your Virtual Dental Care account
3. Begin your call

Vision – Plan Design & Contributions

The vision benefits are provided by MetLife using the Davis Vision Network. Please refer to the table below for a brief description of the vision benefits.

MetLife PPO	In-Network	Non-Network
Network	Davis Vision PPO provider	
Copays		
Exams	$10 copay	
Materials	$20 copay	
Covered Services		
Eye Exams	$10 copay	$10 copay $45 allowance
Frames	$20 copay, frames covered up to $135 , 20% discount after $135	$20 copay, frames covered up to $70
Contact Lenses	$20 copay, contacts covered up to $135 , 15% discount after $135	$20 copay, contacts covered up to $105
Service Frequencies		
Exams & Lenses	Every calendar year	
Frames	Every two calendar years	

Vision Bi-Weekly Plan Rates

Coverage Tier	Bi-weekly Contribution
Employee	$1.29
Employee + Spouse	$2.17
Employee + Children	$2.33
Family	$3.51

If you enroll in dental, the plan includes a vision discount program. The discount program is offered at no cost to you, however, is not the same as an insured vision plan. You may receive discounts on vision care services or glasses, etc. from a provider who is under contract with the Davis Vision network. For example, if you go to a Davis Vision provider for an exam, you may receive a discount off the out-of-pocket fee (15% on average), however there is not the $10 copay. A discount program will provide some out-of-pocket savings for employees who did not elect vision insurance

MetLife Contact Information

855-MET-EYE1

https://www.metlife.com/

Finding a Dental or Vision Provider

Just like the medical insurance, utilizing an In-Network dental or vision provider provides the greatest benefit. To find an In-Network dental or vision provider you can go to **https://www.metlife.com/.** and follow the steps below.

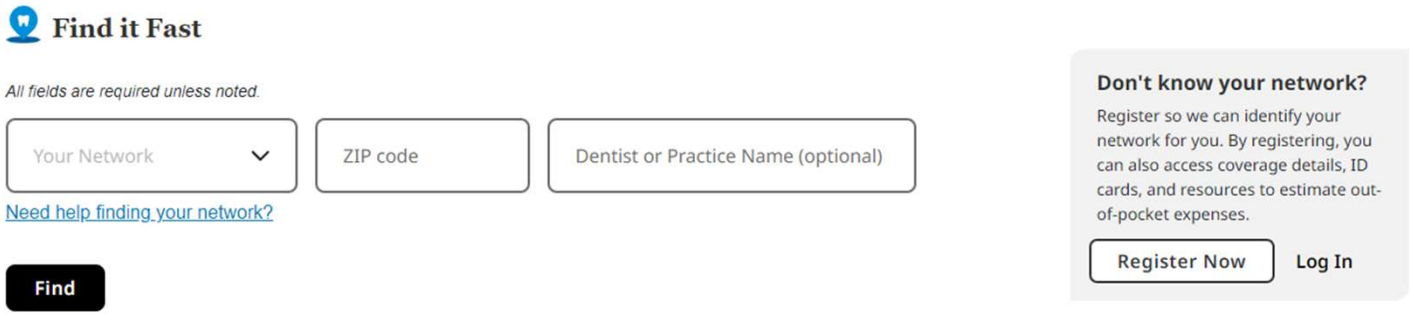
- Hover over **My Account/Login**
- Select **Find a Provider**

Finding a Dental Provider

- **Dental: Select PPO**
- Dental Network is PDP

Finding a Vision Provider

- Select **Find a Vision Provider** at the top of the screen
- Choose Davis Vision



Find a Provider On the Go

Download our mobile app to find a dentist or vision provider in MetLife's networks and access your ID card from your phone or tablet.

Basic Life / AD&D & Disability

BASIC TERM LIFE / ACCIDENTAL DEATH & DISMEMBERMENT

North America Central School Bus has partnered with MetLife to provide a Basic Term Life and AD&D insurance benefit. **This coverage is provided at no cost to you.** Be sure to submit your beneficiary form to ensure your loved ones receive this benefit in the event of your death.

AD&D benefits are payable if you are injured or die as a result of an accident, and the injury or death is independent of sickness and all other causes. The benefit amount depends on the type of loss incurred and is either all or a portion of the principal sum noted above.

Union employees, please reach out to your local union to confirm eligibility.

Living Care / Accelerated Death Benefit

You are eligible to receive 50% of the amount of your life insurance benefit up to a maximum of $25,000 if you have been diagnosed with a terminal illness.

Age Reductions

Your life insurance benefits and guaranteed issue amounts are subject to age reductions. This means at age 65, coverage reduces to 65% of your original life insurance benefit amount. At age 70+, amounts reduce to 50%.

SHORT TERM DISABILITY

North America Central School Bus provides short term disability at no additional cost to you. Short term disability provides financial protection in the unfortunate event that you become disabled and are unable to work due to a non-work-related illness or injury. All short-term disability claims are subject to approval and may be approved for up to 26 weeks. Short term disability is calculated as a percentage of your base salary with a maximum amount of $325 per week.

Filing a Claim with MetLife for Short Term Disability Contact Information

- **Call MetLife at 833-622-0135 to have a disability intake specialist walk you through the process**
- **Disability claims can be filed by phone or through MetLife MyBenefits portal**

Voluntary life & Disability

VOLUNTARY LIFE AND DISABILITY COVERAGES

Current economic times emphasize the importance of protecting your paycheck and your family's financial well-being. Everyone should have a solid foundation, which includes life and disability insurance, to help shift the risk of using your own money in the case of disability or early death. North America Central School Bus has partnered with MetLife to provide you with the opportunity to purchase Voluntary Life / AD&D for yourself, your spouse and your child(ren). You may also purchase long term disability coverage at this time. If you enroll during your initial eligibility period, you can elect up to the guaranteed issue amount without having to answer health questions.

Voluntary Life / AD&D Elections

You may elect Voluntary Life / AD&D insurance for yourself in increments of $10,000, with a maximum of $500,000. You will need to provide evidence of insurability (EOI) for any amount of coverage if you have previously waived coverage. This issuance is subject to underwriting. If you are newly eligible, the guaranteed issue amount is $150,000 and no EOI is needed.

You must elect Voluntary Life / AD&D insurance for yourself in order to elect Voluntary Life / AD&D insurance for your spouse and/or child(ren). The amount of Voluntary Life / AD&D insurance for your spouse is dependent on the amount you elect for yourself. You cannot elect a higher life insurance amount for your dependents than you elect for yourself.

For your spouse, you may elect Voluntary Life / AD&D insurance in increments of $5,000 up to 100% of your elected amount, not to exceed $100,000. If you have previously waived coverage for you or for your spouse, you will be required to provide evidence of insurability. If you are newly eligible, the guaranteed issue amount is $35,000 and no EOI is needed.

If you elect Voluntary Life / AD&D insurance for your child(ren), each child will be covered for a flat $10,000.

Age Reductions

The same reduction rules apply to the Voluntary Life / AD&D insurance as they do for the Basic Life insurance. Benefit payout drops to 65% of elected amount at age 65 and drops to 50% at age 70 or older.

The Voluntary Life / AD&D insurance policy is fully portable (transferrable) which means you can take it with you and remain protected if your employment ends.

Beneficiary Requirement

You must complete and return the beneficiary form for the company paid coverage, regardless of whether you elect the above-mentioned voluntary coverages.

If you die, your beneficiary will get full life benefit amount. If you die of an accident, beneficiary will get additional AD&D benefit amount. For example: You select $50,000 in Life / AD&D benefits. If you die, beneficiary gets $50,000. If you die of an accident, beneficiary gets an additional $50,000.

Voluntary life & AD&D Rates

VOLUNTARY LIFE AND AD&D RATES

To select your benefit amount and calculate your premium amount do the following:

.Find your age bracket in the far-left column.

.You may elect 5x your salary, up to $500,000 in coverage (increments of $10,000).

. Please note: Benefits listed reduce to 65% of benefit at age 65 and 50% at age 70. Please keep this in mind when making your election

IMPORTANT

If your desired election is not shown across the top of the chart below, you can calculate your bi-weekly deduction by following the example below.

Example: $30,000 election, 38 years old:

30,000 x **.19** / 1,000 x 12 / 26 = $2.63 per paycheck

Election x **Rate** / 1,000 x 12 / 26

Age Band	Rate	$10,000	$50,000	$100,000	$150,000	$200,000	$300,000	$400,000	$500,000
<24	$0.09	$0.42	$2.08	$4.15	$6.23	$8.31	$12.46	$16.62	$20.77
25-29	$0.10	$0.46	$2.31	$4.62	$6.92	$9.23	$13.85	$18.46	$23.08
30-34	$0.11	$0.51	$2.54	$5.08	$7.62	$10.15	$15.23	$20.31	$25.38
35-39	$0.19	$0.88	$4.38	$8.77	$13.15	$17.54	$26.31	$35.08	$43.85
40-44	$0.28	$1.29	$6.46	$12.92	$19.38	$25.85	$38.77	$51.69	$64.62
45-49	$0.46	$2.12	$10.62	$21.23	$31.85	$42.46	$63.69	$84.92	$106.15
50-54	$0.74	$3.42	$17.08	$34.15	$51.23	$68.31	$102.46	$136.62	$170.77
55-59	$1.13	$5.22	$26.08	$52.15	$78.23	$104.31	$156.46	$208.62	$260.77
60-64	$1.75	$8.08	$40.38	$80.77	$121.15	$161.54	$242.31	$323.08	$403.85
65-69*	$3.12	$9.36	$46.80	$93.60	$140.40	$187.20	$280.80	$374.40	$468.00
70-74**	$5.57	$12.85	$64.27	$128.54	$192.81	$257.08	$385.62	$514.15	$642.69
75-79**	$9.17	$21.16	$105.81	$211.62	$317.42	$423.23	$634.85	$846.46	$1,058.08
80+**	$18.54	$42.78	$213.92	$427.85	$641.77	$855.69	$1,283.54	$1,711.38	$2,139.23

*Benefits reduce to 65% of covered benefit at age 65

**Benefits reduce to 50% of covered benefit at age 70

(Premiums above reflect reductions)

Voluntary Life & AD&D Rates

Follow the method described on the previous page to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. Keep in mind your spouse's rate is based on your age, so find your age in the far-left column.

Age Band	Rate	$5,000	$10,000	$25,000	$50,000	$100,000
<24	$0.09	$0.21	$0.42	$1.04	$2.08	$4.15
25-29	$0.10	$0.23	$0.46	$1.15	$2.31	$4.62
30-34	$0.11	$0.25	$0.51	$1.27	$2.54	$5.08
35-39	$0.19	$0.44	$0.88	$2.19	$4.38	$8.77
40-44	$0.28	$0.65	$1.29	$3.23	$6.46	$12.92
45-49	$0.46	$1.06	$2.12	$5.31	$10.62	$21.23
50-54	$0.74	$1.71	$3.42	$8.54	$17.08	$34.15
55-59	$1.13	$2.61	$5.22	$13.04	$26.08	$52.15
60-64	$1.75	$4.04	$8.08	$20.19	$40.38	$80.77
65-69*	$3.12	$4.68	$9.36	$23.40	$46.80	$93.60
70-74**	$5.57	$6.43	$12.85	$32.13	$64.27	$128.54
75-79**	$9.17	$10.58	$21.16	$52.90	$105.81	$211.62
80+**	$18.54	$21.39	$42.78	$106.96	$213.92	$427.85

*Benefits reduce to 65% of covered benefit at age 65
**Benefits reduce to 50% of covered benefit at age 70
(Premiums above reflect reductions)

Child(ren) Premium Table (26 deductions per year)
Benefit Amount $10,000 Rate per $1,000: $0.19
Deduction: $0.88

Note: Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the above table

If you would like to calculate the total premium for your Voluntary Term Life and AD&D benefits (for your own information), enter the appropriate premium amounts below and add them to obtain a total.

_____ + _____ + _____ =_____

Employee Premium | Spouse Premium | Child(ren) Premium | Total Premium

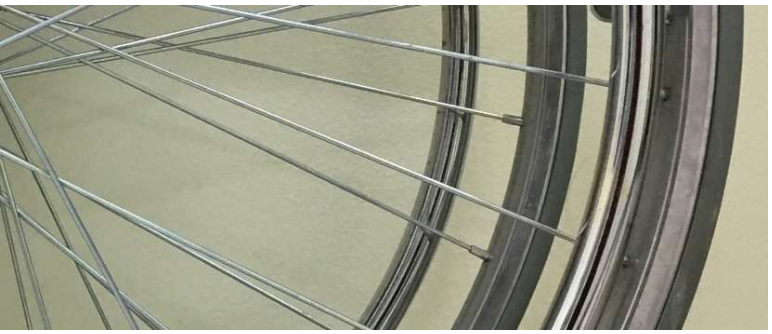
Premium = total per Paycheck

Voluntary Long-Term Disability

You must be actively at work (able to perform all normal duties of your job) to be eligible for long term disability coverage. If you become disabled while covered under this policy, there is an elimination period before benefits are payable. Benefits begin 180 days after the onset of your disabling injury or illness. The LTD benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed $5,000.

If you become disabled prior to age 62, benefits are payable to age 65 of your Social Security Normal Retirement Age. At age 62 (and older), the benefit period will be based on a reduced duration schedule.

Disabilities which occur during the first 12 months of coverage due to a pre-existing condition that began during the 12 months prior to coverage are excluded. All employees will be required to provide evidence of insurability if they did not enroll when they were first eligible.



Voluntary LTD Rates

Use the rates in the age/rate to calculate your premium for voluntary long term disability coverage in the worksheet below, using the example on the next page as a guide.

Benefit and Premium Calculation Example: a 42-year-old employee earning $42,000/year	
A. Enter your Annual Salary	$42,000
B. Enter the monthly benefit percentage	60%
C. Multiply “A” times “B”	$25,200
D. Divide “C” by 12	$2,100
E. Enter the maximum monthly benefit	$5,000
F. Enter the lesser of “D” or “E”, this is your benefit amount	$2,100
G. Divide “F” by 60%	$3,500
H. Multiply “G” by 12	$42,000
I. Enter the rate for your age (from the Age/Rate Table)	.00542
J. Multiply “H” time “I”	$227.64
K. Enter the annual payable cycle	26
L. Divide “J” by “”K”; this is your premium (cost per paycheck)	$8.76

Age/Rate Table	
Age	Rate (% of payroll)
0-19	.00076
20-24	.00086
25-29	.00152
30-34	.00228
35-39	.00342
40-44	.00542
45-49	.00817
50-54	.0134
55-59	.01663
60-64	.01748
65-69	.01834
70+	.01929

Benefit and Premium Calculation Worksheet	
A. Enter your Annual Salary	
B. Enter the monthly benefit percentage	60%
C. Multiply “A” times “B”	
D. Divide “C” by 12	
E. Enter the maximum monthly benefit	$5,000
F. Enter the lesser of “D” or “E”, this is your benefit amount	
G. Divide “F” by 60%	
H. Multiply “G” by 12	
I. Enter the rate for your age (from the Age/Rate Table)	
J. Multiply “H” time “I”	
K. Enter the annual payable cycle	26
L. Divide “J” by “”K”; this is your premium (cost per paycheck)	

Voluntary Benefits

HOSPITAL INDEMNITY COVERAGE

Focus on recovery during a hospital stay – not your out-of-pocket costs. A hospital confinement due to an illness or injury can happen to anyone. Chances are when it occurs you will have unplanned expenses to pay. Will you be prepared?

Coverage Tier	Bi-Weekly Rates
Employee Only	$12.65
Employee+Spouse	$24.68
Employee+Child(ren)	$18.09
Family	$30.12

WHAT IS HOSPITAL INDEMNITY INSURANCE?

Hospital Indemnity Insurance provides a benefit payment directly to you to help pay for out-of-pocket healthcare costs or other household expenses which can pile up during a hospital stay. No matter what other coverage you may have, this benefit can be used however you choose.

WHAT IS THE BENEFIT AMOUNT?

$1,000 per hospital admission per insured, per calendar year

$200 per day of hospital/ICU confinement, 30 day maximum per year

ACCIDENT COVERAGE

Accidents happen every day. Did you know almost thirty-nine million emergency room visits a year are due to an injury? If you were injured from an accident, chances are you will have expenses that you were not anticipating-will you be prepared? Accident Insurance can help you deal with those expenses.

MetLife offers an accident coverage plan that can help you with your medical deductibles and co-pays, and cover household expenses like groceries, mortgage payments and childcare, which can begin to pile up if you must take some time off from work.

Coverage Tier	Bi-Weekly Rates
Employee Only	$4.77
Employee+Spouse	$7.96
Employee+Child(ren)	$8.09

Covered Accidents May Include

- Broken Bones
- Comas
- Concussions
- Stitches
- Burns

Wellness Benefit

This Accident benefit pays $50 per calendar year per insured individual if a covered cancer wellness/health screening is performed including:

- Stress Test
- Mammography
- Blood Tests
- Pap Smear
- PSA
- Colonoscopy
- Chest X-Ray

MetLife Contact Information

800-GET-MET8

https://www.metlife.com/

Voluntary Benefits

CRITICAL ILLNESS COVERAGE

It's true – a serious medical event such as cancer, heart attack or stroke could leave you in a period of financial difficulty. Even if you have major medical coverage, there are typically uncovered expenses to consider, such as deductibles and copayments, travel expenses to and from treatment centers and the loss of wages.

MetLife offers a critical illness coverage plan that offers the protection you need to concentrate on what is most important – your treatment, care and recovery.

You can choose a benefit amount for yourself up to $30,000 in increments of $5,000. Your spouse can get covered at 50% of your benefit amount. Coverage may be subject to Evidence of Insurability.

Dependent Children up to age 26 are automatically covered at 25% of the employee coverage amount.

Benefits reduce by 50% on the policy anniversary date following the insured's 70th birthday.

Covered Critical Illness Conditions May Include:

Heart attack
Kidney Failure
Coma
Cancer
Stroke
Major Organ Failure
Coronary Artery Bypass Graft

Wellness Benefit

This benefit pays $50 per calendar year per insured individual if a covered cancer wellness/health screening is performed including:

Stress Test
Mammography
Blood Tests
Pap Smear
Skin Cancer Biopsy
PSA
Colonoscopy
Chest X-Ray

Employee Bi-Weekly Deduction

	Benefit Amount	<30	30-39	40-49	50-59	60-69	70+
Non-tobacco	$5,000	$0.99	$1.57	$3.09	$5.72	$8.93	$17.56
	$10,000	$1.98	$3.14	$6.18	$11.45	$17.86	$35.12
	$15,000	$2.98	$4.71	$9.28	$17.17	$26.79	$52.68
	$20,000	$3.97	$6.28	$12.37	$22.89	$35.72	$70.25
	$25,000	$4.96	$7.85	$15.46	$28.62	$44.65	$87.81
	$30,000	$5.95	$9.42	$18.55	$34.34	$53.58	$105.37
Tobacco	$5,000	$1.52	$2.56	$5.84	$12.28	$20.98	$38.93
	$10,000	$3.05	$5.12	$11.68	$24.55	$41.95	$77.86
	$15,000	$4.57	$7.68	$17.52	$36.83	$62.93	$116.79
	$20,000	$6.09	$10.25	$23.35	$49.11	$83.91	$155.72
	$25,000	$7.62	$12.81	$29.19	$61.38	$104.88	$194.65
	$30,000	$9.14	$15.37	$35.03	$73.66	$125.86	$233.58

Spouse Bi-Weekly Deduction

	Benefit Amount	<30	30-39	40-49	50-59	60-69	70+
Non-tobacco	$2,500	$0.50	$0.78	$1.55	$2.86	$4.47	$8.78
	$5,000	$0.99	$1.57	$3.09	$5.72	$8.93	$17.56
	$7,500	$1.49	$2.35	$4.64	$8.58	$13.40	$26.34
	$10,000	$1.98	$3.14	$6.18	$11.45	$17.86	$35.12
	$12,500	$2.48	$3.92	$7.73	$14.31	$22.33	$43.90
	$15,000	$2.98	$4.71	$9.28	$17.17	$26.79	$52.68
Tobacco	$2,500	$0.76	$1.28	$2.92	$6.14	$10.49	$19.47
	$5,000	$1.52	$2.56	$5.84	$12.28	$20.98	$38.93
	$7,500	$2.28	$3.84	$8.76	$18.42	$31.47	$58.40
	$10,000	$3.05	$5.12	$11.68	$24.55	$41.95	$77.86
	$12,500	$3.81	$6.40	$14.60	$30.69	$52.44	$97.33
	$15,000	$4.57	$7.68	$17.52	$36.83	$62.93	$116.79

Employee Assistance Program

Life brings new questions and challenges every day. Whether you're looking for childcare or help with an older relative, trying to manage your personal finances, or coping with a health issue, the Employee Assistance Program, Uprise Health, offers fast, free, confidential help whenever you need it.

Uprise Health can help you with almost any personal or work-related issue. All employees have access to the Employee Assistance Program (EAP). This program provides assistance to you and your household members at no cost to you.

You have unlimited access to support and helpful resources on our website, and you can consult with a professional counselor via telephone.

• Face-to-face counseling sessions with an Uprise Health network provider — and up to three sessions are free of charge as part of Uprise Health.

• Free initial 30-minute consultation with an attorney, with a 25% discount on attorney services thereafter.

• Unlimited telephonic support for financial problems or planning needs, and referral for face-to-face for more complex issues are provided for a fee.

Support and guidance is available online for assistance with family and personal issues at worklife.uprisehealth.com and by phone at 1-800-386-7055.

Uprise Health Contact Information

Phone: 800-386-7055

Web: worklife.uprisehealth.com

Access Code: worklife

HEALTH

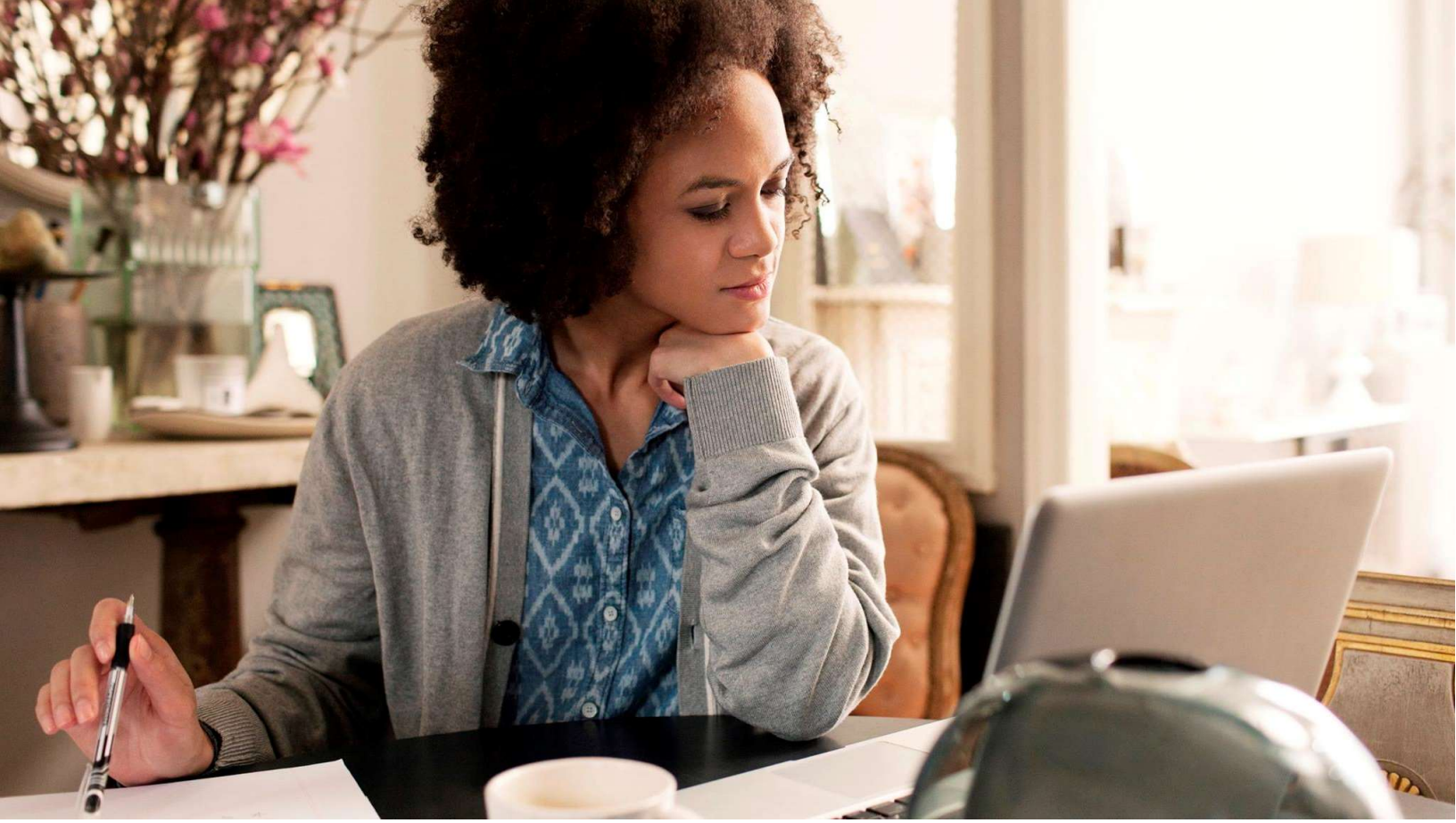
+ Health Living
+ Stress Management
+ Mental Health
+ Diet and Fitness
+ Overall Wellness

FAMILY

+ Parents Support
+ Child and Elder Care
+ Learning Programs
+ Special Needs Help

FINANCIAL

+ Legal Issues
+ Will Preparation
+ Taxes and Debt
+ ID Theft Services
+ Financial Planning Tools and Assistance



401(K) Plan & Paid Time Off

401(k) PLAN

The 401(k) plan is administered through Principal. NACSB will match $.50 for each $1.00 invested up to a maximum of 6% of your annual salary. You may enroll on the first day of the month after your 90th day of employment or at the 1st of the month every month thereafter. You may drop to zero at anytime; however, deferral percentages can only be changed at the beginning of the month. Withdrawals are subject to plan terms and IRS guidelines.

You may reach out to Principal at (800) 547-7754 or go to www.principal.com for additional information or to access your account.

PAID TIME OFF

North America Central School Bus provides accruable vacation, sick and personal time based on seniority and current company policy. Refer to your employee handbook for further details.

QUESTIONS?

Should you have questions about the enclosed material, please contact:

The Human Resources department

815-409-4000 ext. 4021

Contact Information

Benefit	Phone Number	Website
Medical		
BCBSIL – PPO	Membership: (800) 541-2768 Claims/Benefits: (800) 541-2767	www.bcbsil.com
BCBSIL – HMO	Membership: (800) 892-2803 Claims/Benefits: (800) 420-8774	www.bcbsil.com
Dental		
MetLife	800-GET-MET8	https://www.metlife.com/
Vision		
MetLife	855-MET-EYE1	https://www.metlife.com/
Flexible Spending Account (FSA)		
Chard-Snyder	(800) 982-7715	www.Chard-Snyder.com
Life and AD&D / Voluntary Life and AD&D		
MetLife	800-GET-MET8	https://www.metlife.com/
Short-Term Disability		

Contact Information

Benefit	Provider	Phone Number
MetLife	833-622-0135	https://www.metlife.com/
Voluntary Long-Term Disability		
MetLife	800-GET-MET8	https://www.metlife.com/
Hospital Indemnity		
MetLife	800-GET-MET8	https://www.metlife.com/
Accident		
MetLife	800-GET-MET8	https://www.metlife.com/
Critical Illness		
MetLife	800-GET-MET8	https://www.metlife.com/
Employee Benefits Hotline		
MetLife	800-GET-MET8	https://www.metlife.com/
401(k)		
Principle	(800) 547-7754	www.principal.com
Employee Assistance Program		
Uprise Health	(800) 386-7055	www.worklife.uprisehealth.com Access Code: worklife
COBRA		
Wex	(877) 765-8810, Option 2	www.wexinc.com

Important Annual Notices

Important Notice from NACSB About Your Prescription Drug Coverage, Medicare, and Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with NACSB 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) NACSB has determined that the prescription drug coverage offered by the NACSB is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

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 coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back at the next annual enrollment opportunity or qualified life event.

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 this plan 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…

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).

Or contact the person listed below.

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 **NACSB** changes. You also may request a copy of this notice at any time.

Effective Date: 10/1/2024 Employer Name: North America Central School Bus

Contact Name/Title: Ronna Flanagan, Benefits & Compensation Manager

Address: 3033 W. Jefferson St. Suite 220 Joliet, Illinois 60435

Phone: 815-474-7487

Email: r.flanagan@illinois-central.com

Notice of Special Enrollment Rights

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

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for 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).

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.

Medicaid or CHIP

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

To request special enrollment or obtain more information, please contact the plan administrator (see cover page for contact information).

Newborns' and Mothers' Health Protection Act

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 of 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

Mental Health Parity & Addiction Act

The Mental Health Parity and Addiction Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (see cover page for contact information).

Women's Health and Cancer Rights Act

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). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact your plan administrator (see cover page for contact information).

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

For additional information, contact your plan administrator (see cover page for contact information).

Patient Protections

NACSB generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator (see cover page for contact information).

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra/main.htm

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http;//www.dol.gov/vets

An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

Health Insurance Marketplace Coverage Options and Your Health Coverage

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you’ve had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children’s Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and

enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**.
Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact the HR department.

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.

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 **North America Central School Bus**	**4. Employer Identification Number (EIN)** **20-0991676**	
5. Employer address **3033 W. Jefferson St. Suite 220**	**6. Employer phone number** **815-474-7487**	
7. City **Joliet**	**8. State** **Illinois**	**9. Zip code** **60435**
10. Who can we contact about health coverage at this job? **Ronna Flanagan**		
11. Phone number (if different from above)	**12. Email address** **r.flanagan@illinois-central.com**	

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

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are: full-time, hourly or salaried; part-time are eligible for certain benefits.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: your legal spouse, regardless of gender, and your natural, step or adopted children until the end of the month in which they reach age 26
  - ☐ We do not offer coverage

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

** Even if your employer intends this 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.

Your Information. Your Rights. Our Responsibilities.

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.

Effective Date: 10/1/2024

Privacy Officer: Ronna Flanagan

Title: Benefits & Compensation Manager

Email: r.flanagan@illinois-central.com

Phone: 815-409-4010

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 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, and we may say “no” if it would affect your care.

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 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 on page 1.
- 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.

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.

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.
- 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, and we will mail a copy to you.

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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)	**KANSAS – Medicaid**
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: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – 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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH DAKOTA - Medicaid	**SOUTH DAKOTA - Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

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 1/31/2026)

ABOUT THIS GUIDE

This benefit summary provides selected highlights of North America Central School Bus employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the Company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. North America Central School Bus reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.

North America Central School Bus