The Leona Group

2015-2016 Medical Benefit Plan Design

PLAN NAME Provider Network		BASE PLAN Choice		BUY-UP PLAN Choice		CONSUMER-DRIVEN PLAN Choice	
		In -Network	**Out-of-Network**	**In -Network**	**Out-of-Network**	In -Network	Out-of-Network
Policy Year Deductible	Single	$750	$3,500	$350	$2,000	$2,000	$4,000
	Family	$1,500	$6,500	$700	$4,000	$4,000	$8,000
Coinsurance		20%	50%	15%	50%	20%	50%
Out of Pocket Maximum		Includes Deductible, Coinsurance & Copays		Includes Deductible, Coinsurance & Copays		Includes Deductible, Coinsurance & Copays	
	Single	$3,000	$11,000	$2,100	$6,500	$4,000	$12,000
	Family	$6,000	$21,500	$4,200	$13,000	$8,000	$24,000
Maximum Annual Benefit		Unlimited		Unlimited		Unlimited	
Office Visits (PCP/SCP)		$30/$60 Copay	Ded, then 50%	$15/$30 Copay	Ded, then 50%	Ded, then 20%	Ded, then 50%
Preventative Care		$0	n/a	$0	n/a	$0	n/a
Lab, X-Rays & Nuclear Medicine							
	Lab Work	Ded, then 20%	Ded, then 50%	Ded, then 15%	Ded, then 50%	Ded, then 20%	Ded, then 50%
	X-Rays	Ded, then 20%	Ded, then 50%	Ded, then 15%	Ded, then 50%	Ded, then 20%	Ded, then 50%
	MRI, CAT, PET & Nuclear Medicine	Ded, then 20%	Ded, then 50%	Ded, then 15%	Ded, then 50%	Ded, then 20%	Ded, then 50%
Durable Medical Equipment		Ded, then 20%	Ded, then 50%	Ded, then 15%	Ded, then 50%	Ded, then 20%	Ded, then 50%
Hospital Services		Ded, then 20%	Ded, then 50%	Ded, then 15%	Ded, then 50%	Ded, then 20%	Ded, then 50%
Urgent Care		$60 Copay	$60 Copay	$40 Copay	$40 Copay	Ded, then 20%	Ded, then 50%
Emergency Room		$250 Copay		$200 Copay		Ded, then 20%	
Prescription Drugs							
	Retail	30-day Supply		30-day Supply		30-day Supply	
		$15/$40/$70/$120	In-Network Copay + 50%	$15/$35/$60/$120	In-Network Copay + 50%	$15/$40/$70/$120	In-Network Copay + 50%
	Mail Order	90-day Supply		90-day Supply		90-day Supply	
		2.5 X Retail	n/a	2.5 X Retail	n/a	2.5 X Retail	n/a
HRA Contribution (Single/Family)		n/a		n/a		n/	$500 / $1,000
TeleDoc		$40 Copay	n/a	$40 Copay	n/a	$40 Copay	n/a

Leona Benefit Plan Premiums 2015-2016

	Engaged Rates Per Pay Period	Non-Engaged Rates Per Pay Period
Base Plan 12-Month		
Employee Only	$17.50	$37.50
Employee + Child/Children	$25.00	$45.00
Employee + Spouse	$30.00	$55.00
Employee + Family	$45.00	$75.00
Base Plan 10-Month		
Employee Only	$21.00	$45.00
Employee + Child/Children	$30.00	$54.00
Employee + Spouse	$36.00	$66.00
Employee + Family	$54.00	$90.00
Buy-up Plan 12-Month		
Employee Only	$37.50	$57.50
Employee + Child/Children	$67.50	$87.50
Employee + Spouse	$80.00	$105.00
Employee + Family	$110.00	$140.00
Buy-up Plan 10-Month		
Employee Only	$45.00	$69.00
Employee + Child/Children	$81.00	$105.00
Employee + Spouse	$96.00	$126.00
Employee + Family	$132.00	$168.00
CDHP 12-Month		
Employee Only	$0.00	$20.00
Employee + Child/Children	$7.50	$27.50
Employee + Spouse	$12.50	$37.50
Employee + Family	$27.50	$57.50
CDHP 10-Month		
Employee Only	$0.00	$24.00
Employee + Child/Children	$9.00	$33.00
Employee + Spouse	$15.00	$45.00
Employee + Family	$33.00	$69.00

Dental Plan Premiums (Per Pay Period)

12-Month		
Employee Only	$0.00	
Employee + Child/Children	$14.43	
Employee + Spouse	$15.60	
Employee + Family	$20.26	
10-Month		
Employee Only	$0.00	
Employee + Child/Children	$17.32	
Employee + Spouse	$18.71	
Employee + Family	$24.31	

Vision Plan Premiums (Per Pay Period)

12-Month		
Employee Only	$0.00	
Employee + Child/Children	$2.71	
Employee + Spouse	$2.58	
Employee + Family	$3.98	
10-Month		
Employee Only	$0.00	
Employee + Child/Children	$3.25	
Employee + Spouse	$3.09	
Employee + Family	$4.78	

Waiver Payment (Per Pay Period)

Medical Waiver	$83.34 per pay period	
Dental Waiver	$20.84 per pay period	
Vision Waiver	N/A	

The Leona Group

Annual Core Benefits Open Enrollment for 2015-2016

Frequently Asked Questions

MEDICAL INSURANCE BENEFITS

Q: Will we have the same medical insurance this year?

A: The two medical insurance plans -- our Base PPO and our Buy-Up PPO will still be available but will both have three plan design changes. Those changes will take effect on July 1, 2015. The changes are:

- Out-of-Pocket Maximums will increase because of Affordable Care Act requirements. On the Base plan, the OPMs will go from $2,500 single/$5,000 family to $3,000 single/$6,000 family. On the Buy-Up plan, they will change from $1,600 single/$3,200 family to $2,100 single/$4,200 family.
- Coinsurance for out-of-network medical services will increase from 40% to 50%
- TeleDoc phone & video consultation service is being added

Q: I heard something about a third medical insurance plan option. What's that all about?

A: Yes. We are adding a third medical plan option to give you greater choice in your medical insurance coverage. The third option is a different type of insurance plan known as a Consumer Driven, High Deductible Health Plan (CDHP).

Q: What is a Consumer Driven Health Plan (CDHP)?

A: The Consumer Driven Health Plan (CDHP) offers comprehensive medical coverage as do the two PPO plans. Under the CDHP, almost all medical services are subject to the plan's deductible and co-insurance instead of co-payments like on the existing PPO plans.

Q: Is a CDHP just like a PPO?

A: No, although they do share some features as noted here:

- Preventative Care services are still covered at 100% with no co-payment or coinsurance required from the employee
- Prescriptions will be covered with the same co-payments that are in effect on our Base PPO plan
- The new TeleDoc feature will have the same copay as the Base & Buy-Up PPO plans -- $40 per consultation
- You will still have a higher level of benefits for using in-network medical service providers
- You can use the money that you put into a Flexible Spending Account to pay for medical expenses not covered by the plan (co-payments, co-insurance, deductibles)

Q: What will be different about the CDHP?
A: Except for the co-payments for TeleDoc and Rx, and the 100% coverage for preventative care, every other medical service is subject to deductible and co-insurance.

Q: Does that mean that doctor's office visits won't have a co-pay like they do on the PPO plans?
A: Yes. On the CDHP, doctors' office visits for non-preventative services will be subject to meeting your annual deductible and then paying your part of the coinsurance. So if you go to the doctor because you are ill and you have not met your annual deductible, you will have to pay for the full cost of the office visit, and that amount will go toward satisfying your annual deductible.

Q: If I have to pay for all the claims myself, why would I want to enroll in the CDHP?
A: The CDHP will have much lower premiums than the two PPO plans. Also, you won't have to actually pay all the claims yourself. The CDHP will come with an employer-funded Health Reimbursement Arrangement (HRA) to help you pay for claims.

Q: What is an HRA?
A: An HRA (Health Reimbursement Arrangement) is an account established for you and funded by your employer. For our new CDHP, we will put $500 into the account for employees who do not have dependents enrolled, and $1000 into the account for employees who enroll family members in their coverage. The money in the HRA account will roll over and build up from year to year if you do not use it.

Q: Can I put money into the HRA?
A: No. Only employer contributions are allowed in the HRA account.

Q: How does the HRA work? Do I have to pay in cash and then get reimbursed?
A: No. When you have a claim for medical services, the medical provider will bill Aetna and Aetna will process the claim. If you have money in your HRA account, Aetna will automatically pay the claim from that account.

Q: What happens if I exhaust my HRA funds?
A: If you have a flexible spending account, you can use that money to pay claims after you exhaust your HRA funds. If you do not have an FSA, then you are responsible for the remaining portion of the deductible once your HRA benefit dollars have been exhausted, and for your coinsurance portion after the deductible has been met.

Q: What happens after I have met the annual deductible on the CDHP plan?
A: After the deductible has been met, then your claims are processed by Aetna and you will be responsible for your portion of the coinsurance. The coinsurance on the CDHP will be 80% paid by the plan and 20% paid by the employee for In-Network claims. If you reach the annual out-of-pocket maximum, the plan will cover the remaining eligible medical expenses at 100% for the rest of the plan year.

Q: How can I keep track of my HRA balance?
A: You will receive an Explanation of Benefits from Aetna after each claim is processed so you know how much you owe for health care expenses.

Q: How is the deductible and out-of-pocket maximum tracked?
A: Your deductible and out-of-pocket maximum for all three medical plans are tracked on a calendar-year basis from January through December. On January 1, 2016, you will start toward meeting your new annual deductible amount.

Q: Are premiums for the new CDHP plan payroll deducted on a pre-tax basis like they are for the two PPO plans?
A: Yes. Premiums for all of our core benefits plans -- medical, dental and vision, are payroll deducted on a pre-tax basis.

Q: What does pre-tax mean?
A: When you are paid, the premiums for your benefit plans are deducted from your total payroll amount before that total is used to calculate how much tax you must pay. So you do not pay taxes on the premiums. This includes federal and state income taxes, social security taxes and Medicare taxes.

Q: How do I know if this new CDHP plan is right for me?
A: Aetna has a plan comparison tool that you can use to compare all 3 plans. Simply log onto Aetna Navigator to use this tool. www.aetnanavigator.com. Instructions on how to use the tool can be found on the home page of the Employee Portal.

Q: Will I receive an ID card for the CDHP?
A: Yes. If you chose to enroll in the CDHP plan, you will receive a new ID card in the mail.

Q: What is happening with medical premiums this year? Are they going up again?
A: We are very happy to announce that if you are engaged in our wellness initiative, there are NO PREMIUM INCREASES for the new plan year. Additionally, there are NO PREMIUM INCREASES for dependent coverage, even if you are not engaged. The only premium that is increasing is for the employee-only, non-engaged tiers on both the Base PPO and the Buy-Up PPO plans. That premium is increasing by $10.00 per month. However, you still have until May 31, 2015 to become engaged and avoid that premium increase.

Q: What is that TeleDoc thing that I heard about?
A: We are adding a new plan benefit on all three of the medical insurance plans called TeleDoc. TeleDoc provides 24/7/365 access to quality medical care through phone and video consultations. You interact with qualified medical doctors who can diagnose your condition, recommend treatment, and prescribe medication. There is a $40 co-payment for each consult. The same co-payment will be in place for all three medical plans.

Q: Is there a pre-existing condition clause on our plan?
A: No. Pre-existing conditions are not excluded from coverage.

Q: Is the network of physicians/hospitals changing?
A: No, it will remain the same.

Q: What are the benefits of staying in-network?
A: Your out-of-pocket costs will be considerably less when you use in-network providers. They have contracted with our administrator -- Aetna -- and have agreed to certain payment rates for the services they provide. Those rates are significantly lower than the "retail" rate for the same services. As a result, your coinsurance portion will be less, and the total claims paid by the plan will be less. When we can control the cost of our claims, we can keep the plan robust and affordable for you.

WELLNESS INITIATIVE

Q: What about wellness? Will we still have to be engaged?
A: Our wellness initiative will continue, and there will continue to be "engaged" and "non-engaged" premium rates for each of the three medical plans.

Q: Will the engagement criteria change?
A: Yes. Beginning in July, there will be two separate paths to engagement. The first path will be the same as it was this year, with four steps that must all be completed by May 31, 2016 in order to be engaged. The list of activities from which you can choose to complete step 4 will probably be amended slightly, but all four steps will be required and you will still be able to receive a $50 gift card from Aetna after completing the first three steps.

There will also be a second path toward engagement, and it is very, very simple. When you have your metabolic screening done in the fall, if you test in the "healthy" range in three out of the five metabolic syndrome categories, then you will automatically be engaged and you will not need to complete any other tasks.

Q: What are the five metabolic syndrome categories?
A: They are

- Waist circumference
- Blood pressure
- HDL Cholesterol
- Triglycerides
- Blood Glucose

Q: What happens if I don't test in the healthy range in three categories?
A: If you do not qualify for engagement by testing in the healthy range in three of the five categories, you can still complete steps 1 - 4 on the other path to engagement. Those steps would need to be completed by May 31, 2016.

DENTAL INSURANCE BENEFITS

Q: Will there be any changes to our dental insurance coverage?
A: We are pleased to say that the dental plan design is not changing and that we are keeping the same plan administrator -- Delta Dental -- with the same network of dental service providers.

Q: Will dental still be provided with no premium cost to me?
A: We will continue to provide employee-only dental coverage at no premium cost to you, but this year, for the first time, we will begin to charge premiums if you wish to cover family members on your dental plan. There will be a four-tier premium structure that mirrors our medical plan tiers -- employee only, employee + child or children, employee + spouse and employee + family.

Q: Why are you making that change?
A: Because enrollment in our dental plan has always been "free", many employees have enrolled their family members on our plan even if they have coverage somewhere else. This causes our plan costs to be greater than necessary, and keeps us from being able to continue to provide this benefit without charging premium. The good news is that most of the other school districts are charging 100% of the cost of dependent coverage to their employees. We will only be charging 50% of the dependent coverage costs.

Q: How much will the dental premiums be for dependent coverage?
A: A list of premiums for all three benefits plans -- medical, dental and vision, can be found on the home page of the employee portal.

VISION INSURANCE BENEFITS

Q: Will there be any changes to our vision insurance coverage?
A: We are pleased to say that the vision plan design is not changing and that we are keeping the same plan administrator -- Aetna -- with the same network of vision service providers. One thing that is changing is the premium tier structure. Currently, there are two tiers -- employee only and employee + family. We will change to a four-tier structure that will mirror our medical plans -- employee only, employee + child or children, employee + spouse and employee + family. We are very pleased to tell you that for the first three tiers, your premiums will be

LOWER than they currently are. The premium for the employee + family tier will increase, but only by $.32 per month.

Q: What are the new premiums for vision insurance?
A: A list of the employee premiums for our three core benefits -- medical, dental and vision insurance -- can be found on the home page of the employee portal

MEDICAL FLEXIBLE SPENDING ACCOUNT

Q: Is there anything I can do to help offset the extra money that is going to be coming out of my check, and my pocket as a result of these changes?
A: If you have not already done so, you can take advantage of our Medical Flexible Spending Account offered through PayFlex. This plan allows you to designate a fixed dollar amount for the year, up to $2500 ($2,550 January 1, 2016 calendar year), and have that amount deducted from your payroll checks in equal amounts each pay period on a pre-tax basis. You receive a pre-paid credit card with your annual designated amount on it, and you can then use that credit card to cover your co-payments, deductibles and co-insurance amounts. Yes, you are still paying for those services, but you are not paying tax on the amount you designate, which saves you all of those tax dollars.

Q: When can I enroll in the Medical Spending Plan?
A: The plan runs on a calendar-year basis and open enrollment will take place in November, 2015 for an effective date of January 1, 2016.

Q: Isn't Payflex a use it or lose it benefit?
A: In 2015 we amended our plan to allow for a rollover of up to $500 which must be used by the end of the following plan year. You should estimate carefully what your annual expenses will be, and do not designate more than you think you will spend. Any unused funds over $500 will not carry over and will be forfeited.

Q: Why do some people have issues with their Payflex card being turned off?
A: Per the IRS, there are periodic audits with the PayFlex plan where you are required to submit receipts and copies of Explanation of Benefits (EOB) to substantiate your purchase(s). Those who do not respond to the audit request will have their cards turned off until the issue is resolved. It is very important to remember to keep your receipts with your tax records.

MISCELLANEOUS QUESTIONS

Q: What else can I do to keep costs down?
A: You can help control the costs of the plan as a whole, as well as controlling your own expenses, by:

- Using in-network providers
- Taking advantage of preventative services covered at 100% such as annual physical exams, mammograms, well-baby care, etc.
- Use the Emergency Room only for true emergencies. You can use Urgent Care, Office Visits, and TeleDoc in non life threatening events.
- Using Aetna's disease management programs
- Carefully reviewing your Explanation of Benefits Forms whenever you get them to review for accuracy for the services rendered.

Q: How much will be deducted from my check each pay?
A: That depends on the specific plan and level of coverage that you purchase. A full list of the employee premiums for our medical, dental and vision plans can be found on the home page of the Employee Portal.

Q: If I buy the Base PPO plan and later decide that I want the Buy-Up PPO or the CDHP, do I have to wait until open enrollment to change?
A: Yes. Open enrollment is the only time of year that you can switch plans.

Q: I was covered on the plan my spouse had at her employer, but she just lost that coverage. Can I enroll in Leona's plan?
A: Yes. That is a qualifying event and you have 30 days from the date she lost her coverage to provide HR with proof that she lost her coverage, and complete the forms required to enroll in our plans. If you do not enroll within the 30-day window, you would not be able to enroll until the next open enrollment period.

Q: What is a qualifying event?
A: While this is not an all inclusive list, qualifying events include the following:
- marriage or divorce
- birth or adoption
- death of an enrolled dependent
- legal guardianship orders
- eligible dependent's loss or acquisition of coverage elsewhere

Q: What if I don't like the plan that I pick, can I cancel my benefits at anytime?
A: No, because premiums for these plans are taken on a pre-tax basis, you cannot drop your coverage in the middle of a plan year unless you experience a qualifying event. If you do experience such an event, you have a 30-day window during which you must notify HR to make a change. If you do not do so within the 30 days, then you cannot make the change until the next open enrollment.

Q: My son is 22 and is not going to school full-time, but he is going part-time and working part-time. Can I enroll him on my coverage?
A: Dependents over the age of 19 may be covered on the medical plan up to age 26 whether or not they are full-time students. Dependents over the age of 19 can only be covered on the dental and/or vision plans if you show proof that they are full-time students (taking at least 12

credit hours). If they are full-time students, they can be covered up to age 25 on dental and/or vision.

Q: Do I have to take coverage?
A: No. You are not obligated to enroll in any of the benefit plans provided for you. In fact, if you show proof that you have coverage somewhere else and you waive our medical and/or dental coverage because of that, you will receive waiver payments for not enrolling in our plans.

Q: How much are the waiver payments?
A: Currently the per-pay-period waiver payments are $83.34 for medical and $20.84 for dental.

Q: Do I have to waive both medical and dental?
A: No. If you have dental coverage somewhere else but not medical, then you can choose to enroll in our medical plan and waive our dental plan, or vice versa. You do not have to waive both.

Q: I do not have coverage elsewhere, but I can't afford to pay the premiums for the coverage Leona offers. Do I have to enroll?
A: You do not have to enroll, but you will not be eligible to receive waiver payments if you don't have coverage somewhere else. Additionally, under the federal Affordable Care Act, you will be penalized when you file your taxes if you cannot show proof that you have medical insurance coverage.

Q: When does my insurance end?
A: If you leave the company or your status changes from full-time to part-time, your benefits end on the last day of the month during which you separate employment or change status.

Q: I am not returning next school year. When do my benefits end?
A: It depends on your work location and your employment classification:

- Full-time, year-round employees in all locations -- benefits end on the last day of the month during which employment ends
- Arizona Teachers -- Benefits end on July 31, 2015*
- Midwest Teachers -- Benefits end on August 31, 2015*

**For teachers with pro-rated salary payments, benefits end when the final pro-rated salary payment is issued provided the teacher completed his/her contractual work days.*

Q: What if I plan to return but get offered a different job in August? When will my benefits end?
A: Benefit termination dates will be retroactively adjusted to the dates noted above and you will be responsible for the cost of any medical, dental or vision services you incurred following that retroactive termination date.

Q: Is the 401(k) plan changing?
A: No, we will continue to match your contributions, dollar for dollar, up to 6% of your base pay. If interested in enrolling or changing the amount that you contribute to the plan, please take a look at the employee portal as all of the information that you need to enroll is posted there.

Q: Any other changes on the horizon?
A: We will be making some changes to the short term disability benefit effective January 1, 2016. New pay continuation levels will be in the 60-70% range and will require one year of service for eligibility. More information will be published later this year.

OPEN ENROLLMENT

Q: **When does Open Enrollment start?**
A: Open enrollment starts on May 11, 2015 and ends on May 22, 2015.

Q: **What can I do during open enrollment?**
A: Open enrollment is the only time of year when you can

- change to a different medical plan
- enroll in medical, dental or vision insurance if you did not enroll when you were originally eligible
- drop medical, dental or vision insurance if you no longer wish to be enrolled
- add or delete dependents from your medical, dental or vision insurance without having a life event (such as marriage, birth, adoption, etc.)

Q: Do I have to do anything during open enrollment?
A: Yes. This year everyone will have to complete a new enrollment form if they want to have dental or vision coverage. Additionally, if you want to make any changes to your plans or your dependents, you will have to complete an enrollment form to reflect those changes.

Q: What happens if I don't get my enrollment form turned in on time?
A: If you have not submitted an enrollment form by May 22, 2015, then you will remain enrolled in whichever medical insurance plan you previously had, but you will no longer be enrolled in the dental or vision insurance coverage. Your dental and vision insurance coverage will terminate on June 30, 2015 and you will not be able to enroll in it again until the following year.

Q: When will the first payroll deduction for the new medical plan be taken?
A: The first deduction will be taken on the July 15, 2015 payroll check.

Q: **Will everyone need to re-enroll? If I'm not making any changes, do I still need to complete an enrollment form?**

A: **Dental and vision** - All full-time employees will need to enroll in the dental and vision plans listing all dependents that are covered by completing an enrollment form. Remember, if your dependent is over the age of 19 they must be going to school on a full-time basis and you must provide proof of full-time student status in order for your overage dependent to be covered on your plan. If proof is not sent, your dependent will not be added. If you do not submit an enrollment form you will not have dental and / or vision as of July 1, 2015. Your next opportunity to enroll will be next open enrollment, May 2016 for a July 1, 2016 effective date.

Medical - You do not need to complete an enrollment form if you are not making changes to medical. If you wish to change plans or add/delete a dependent from your medical coverage, you will need to fill out the change form.

Q: How do I enroll? Where will I find the enrollment form?
A: You must complete an enrollment form for dental and vision coverage and submit to your office manager by May 22, 2015. Enrollment forms will be included on the home page of the Employee Portal with other information on open enrollment.

Q: How long do I have to decide on which plan I want to select?
A: Open enrollment will last for two weeks from May 11-May 22. You must have made your selection and submitted your enrollment forms to your office managers by May 22, 2015.

Q: Do I have to fill out an enrollment form, or will my old coverage just carry forward?
A: **Dental and/or Vision** - Everyone MUST complete an enrollment form to be covered by the dental and/or vision plans for the new plan year beginning July 1, 2015. Enrollment will not automatically carry over. If you do not complete an enrollment form, you will not have any dental and/or vision coverage as of July 1, 2015. For dental and/or vision, you MUST submit FT student schedules showing at least 12 credit hours for overage dependents between 19-25 or your dependents will not be enrolled.

Medical - You do not have to submit a form for medical unless you are making changes.

SUMMARY: WHAT DO I NEED TO DO?

- ★ **Dental -** You MUST complete an enrollment form listing all dependents if you want dental insurance. Overage students (ages 19-25) must be FT students carrying at least 12 credit hours in order to be enrolled. College schedules must be submitted with enrollment forms in order to have coverage for the overage dependent.
    - ○ **If you do not fill out an enrollment form you will not have dental coverage on July 1, 2015 and will not be eligible to enroll until next open enrollment.**
- ★ **Vision** - You MUST complete an enrollment form listing all dependents if you want vision insurance. Overage students (ages 19-25) must be FT students carrying at least 12 credit

hours in order to be enrolled. College schedules must be submitted with enrollment forms in order to have coverage for the overage dependent.

- **If you do not fill out an enrollment form you will not have vision coverage on July 1, 2015 and will not be eligible to enroll until next open enrollment.**

★ Medical - You do not have to submit an enrollment form for medical if you are not making any changes.

★ **Required enrollment forms must be submitted to your office manager (for school-based personnel) or to HR (for corporate office staff) by close of business on May 22nd, 2015.**

★ All changes will go into effect on July 1, 2015 and premiums will be reflected on the July 15, 2015 paycheck.

Q: Who can I contact if I have other questions that were not covered here?
A: Based upon your work location, please contact the following individuals if you need further assistance:

AZ & FL Employees - Contact:
Kim Greene
602.953.2933
kim.greene@leonagroup.com

MI, OH & IN Employees - Contact:
Lisa Smith
517.333.9030
lisa.smith@leonagroup.com