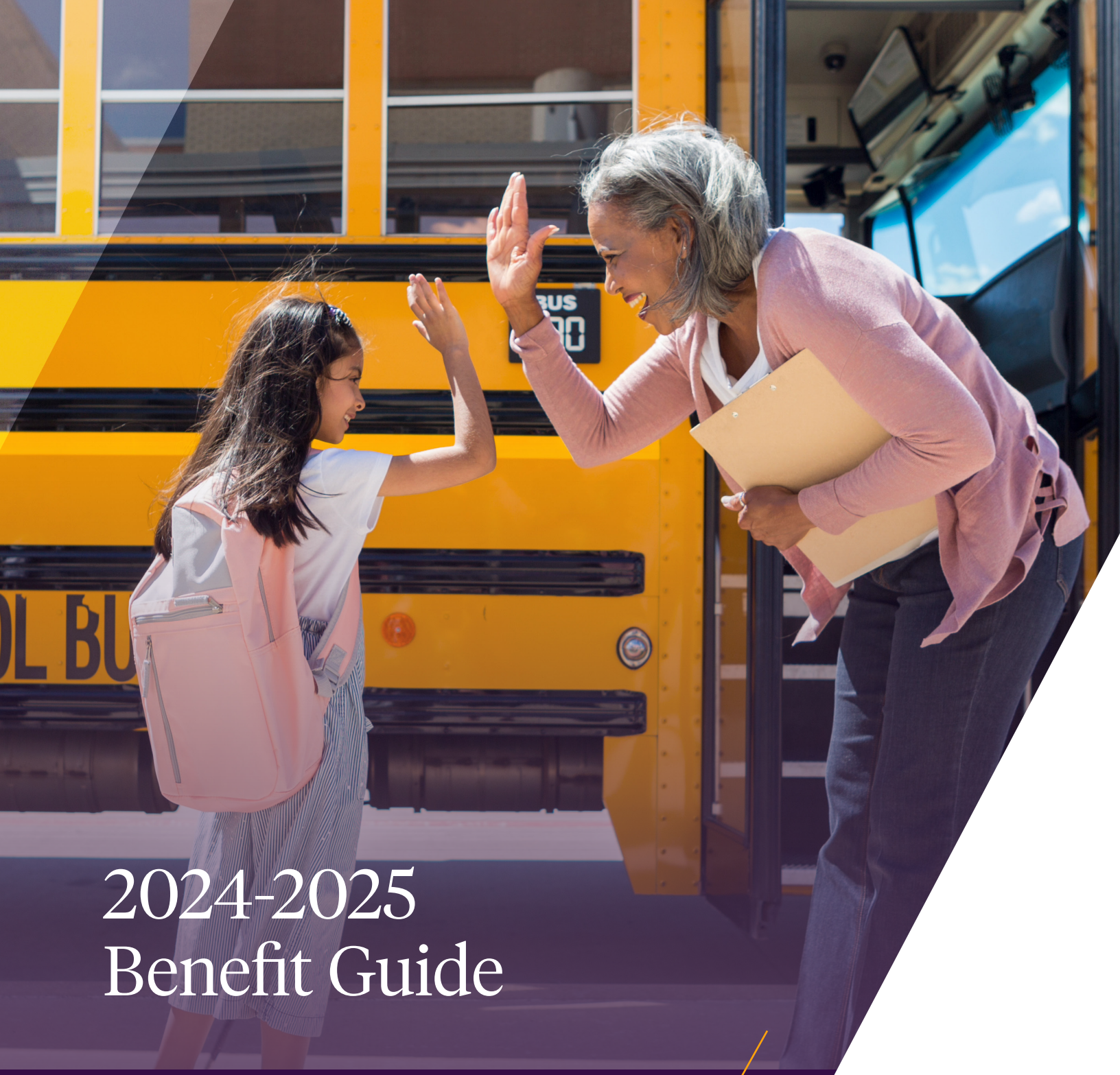

2024-2025 Benefit Guide

LAUREL PUBLIC SCHOOLS

Leavitt Group

Laurel Public Schools strives to provide you and your family with a comprehensive and valuable benefits package.

We want to make sure you're getting the most out of our benefits—that's why we've put together this benefits guide.

Laurel Public Schools invests significant resources into our faculty and staff's health and wellbeing. We hope you will take the opportunity to carefully review these benefits and take advantage of the services offered to you and your family.

Elections you make during open enrollment will become effective on September 1. If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to HR.

New plan changes effective September 1, 2024.

- Laurel Public Schools will be changing health plan carriers from Blue Cross Blue Shield of MT to EBMS with the Joint Powers Trust (JPT).
- Two medical plan options will be offered — a traditional PPO $1,500 deductible plan and a $3,200 high deductible health plan (HDHP).
- Pharmacy benefit manager will be SmithRx.
- Dental plan coverage will change from Delta Dental to EBMS. Only one dental plan benefit will be offered. The dental plan benefit year will be from 9/1/24 - 8/31/25.

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Open Enrollment

Open enrollment for medical, dental, vision, and life insurance is held annually in May. During this time period, employees will have the option to make changes to their current benefits for the new plan year.

Open Enrollment Process

Open enrollment will be May 20 - 31. Employees will be required to meet one-on-one with an American Fidelity representative to make benefit elections.

During open enrollment, employees can:

- Enroll/drop coverage in the medical, dental, vision, or voluntary life plans
- Add/drop dependents' coverage
- Change your medical plan election
- Complete flex elections for the plan year September 2024 - August 2025
- Complete HSA elections for 2024 - 2025

Upon initial hire, employees will work with Laurel Public Schools' benefits personnel to make elections.

Life Insurance

- Changes will be made through the HR department
- Change of beneficiary—life insurance beneficiary form
- Increasing voluntary life insurance—evidence of insurability and Mutual of Omaha enrollment form

WHEN CAN I MAKE CHANGES?

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include things like:

Marriage, divorce, or legal separation

Birth or adoption of a child

Change in child's dependent status

Death of a spose, child, or other qualified dependent

Change in residence

Change in employment status or a change in coverage under another employer-sponsored plan

Your Benefits Plan

Laurel Public Schools is pleased to offer a comprehensive benefits program to our valued employees.

In the following pages, you will learn more about the benefits Laurel Public Schools offers. You will also see how choosing the right combination of benefits can help protect you and your family's health and financial future.

CARRIER	PLAN	WEBSITE	PHONE #
EBMS	Medical	www.ebms.com	(866) 753-1491
EBMS	Dental	www.ebms.com	(866) 753-1491
VSP	Vision	www.vsp.com	(800) 877-7915
Mutual of Omaha	Life, AD&D, Disability	www.mutualofomaha.com	(877) 999-2330
Mutual of Omaha	EAP	www.mutualofomaha.com/eap	(800) 316-2796
Sapphire Resource Connection	EAP	www.sr-connection.com	(866) 767-9511
Recuro Health	Virtual Urgent Care	www.recurohealth.com	855-6RECURO
Laurel Public Schools	Human Resources	www.laurel.k12.mt.us	**Peggy Pollock** peggy_pollock@laurel.k12.mt.us **Maggie Lowell** lpspayroll@laurel.k12.mt.us
Leavitt Group	Benefits Contact	www.leavitt.com/greatwest	**Cindy Zipperian** cindy-zipperian@leavitt.com (406) 443-1060 **Erin Weenum** erin-weenum@leavitt.com (406) 281-7970

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Medical Insurance

INSURED BY: EBMS

Pharmacy Benefit Manager (PBM) — SmithRx

BENEFIT		TRADITIONAL 1500	HDHP 3200
Pre-Tax Savings		**Flex**	**H.S.A.**
Deductible		$1,500 individual $3,000 family	$3,200 individual $6,400 family
Coinsurance		80/20%	100/0%
***Out-of-Pocket Max** *includes deductible & copays*		$3,500 individual $7,000 family	$3,200 individual $6,400 family
Primary Care Visit		$10 copay	Deductible Applies; 0% Coinsurance
Specialist Office Visit		$35 copay	Deductible Applies; 0% Coinsurance
Emergency Room		$100 copay	Deductible Applies; 0% Coinsurance
Preventive Care		Covered 100% — deductible waived	
PRESCRIPTION BENEFITS			
Deductible		$150; waived for generics	Subject to medical plan deductible
Generic		$0	
Preferred		$40	
Non-Preferred		60% to $200	
Specialty	**Formulary**	$100 $200	
	Non-Formulary		
Mail-Order		2 times retail copay for 90-day supply	

As part of your medical plan benefits through EBMS, enrolled employees will receive a **$15,000** life/AD&D policy administered by Mutual of Omaha.

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NEW – Pharmacy Benefit Manager (PBM)

INSURED BY: SMITHRX

Prescription Drug Resources

Visit **www.mysmithrx.com** to find the following information:

- Best pricing on prescription drugs
- Potential cost-saving alternatives
- Mail-order options
  - Amazon Pharmacy
  - Walmart Pharmacy
  - Mark Cuban Cost Plus Drugs
- Specialty Pharmacies
  - Kroger
  - Senderra
- A record of Rx purchases

Mail Order Pharmacies	
amazon pharmacy	Register at www.amazon.com/smithrx. Doctors can send prescriptions via electronic prescribing, fax, or phone. ▸ **Name/E-scribe:** Amazon Pharmacy Home Delivery ▸ **Amazon Pharmacy fax:** (512) 884-5981 ▸ **Amazon prescriber and pharmacy line:** (855) 206-3605
Walmart Pharmacy	Doctors can send prescriptions via electronic prescribing, fax, or phone. ▸ **Walmart Pharmacy fax:** 1 (800) 406-8976 ▸ **Walmart prescriber and pharmacy line:** 1 (800) 273-3455 ▸ **Website:** https://www.walmart.com/cp/1042239
MARK CUBAN CostPlus DRUG COMPANY	See whether your medications are available: https:/costplusdrugs.com/medications. Doctors can send prescriptions via electronic prescribing to: ▸ **Name/E-scribe:** Mark Cuban Cost Plus Drug Company (MCCPD)

Kroger specialty pharmacy	For enrollment assistance, patients can call: (888) 355-4191. Prescribers can visit www.krogerspecialtypharmacy.com and fill out the appropriate forms for the appropriate department. Faxed prescriptions will ONLY be accepted from the prescriber.
SENDERRA Specialty Pharmacy	For enrollment assistance, patients can call: (888) 777-5547. Prescribers can visit https://senderrarx.com/prescribers/forms and fill out the appropriate forms for the appropriate department. Faxed prescriptions will ONLY be accepted from the prescriber.

Retail pharmacies: Here are just a few of the retail pharmacies in our network.

CVS pharmacy | RITE AID | Walgreens | Walmart | COSTCO WHOLESALE

CHAT: www.smithrx.com

P: 844.454.5201 | **E:** help@smithrx.com

SmithRx Connect Program

Help control your medication costs through the SmithRx Connect Program. The SmithRx Connect Program identifies alternate sources for your high-cost specialty and branded medications to be covered at little or no cost to you.

The SmithRx team will help you navigate the process with their team of experts. If you are taking medications that qualify for the program, you will receive communication from the SmithRx team. Please engage with the SmithRx team and provide them the information requested and this will help prevent any delays in accessing your medications at a lower cost.

If you would like more information on this program, call 844-454-5201 or email **help@smithrx.com**.

miBenefits – Member Portal with EBMS

miBenefits

Would you like to know when your medical claims are paid and the payment amounts? Do you need to confirm who in your family is included under your coverage? miBenefits, the secure member portal from EBMS, can help. Get immediate online access to health and wellness information.

GET STARTED

- Go to www.ebms.com
- Click “Login” in upper left corner
- Click “Not a Registered User” and input information exactly as it appears on your ID card
- Username must be an email address

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Virtual Urgent Care

INSURED BY: RECURO HEALTH

24/7 access to board-certified doctors for treatment of common medical concerns with ongoing communication with your doctor.

Affordable

Inproving affordability and access to care for you and your family.

Consult Fee: $35

Coordinated

If needed, urgent care can seamlessly transition to Recuro's ongoing virtual primary care to improve patient health and preempt future issues.

Convenient

Patients can see a board-certified physician wherever they are, whenever they need it.

CONDITIONS TREATED

- Acne/Rashes
- Allergies
- Cold/Flu/Cough
- GI Issues
- Ear Problems
- Fever/Headache
- Insect Bites
- Nausea/Vomiting
- Pink Eye
- Respiratory Issues

Dental Insurance

INSURED BY: EBMS

All employees enrolled in the medical plan are automatically enrolled in the dental plan.

BENEFIT DESCRIPTION	COVERAGE
Deductible	No deductibles apply
Preventive (Class A)	100%
Basic (Class B)	80%
Major (Class C)	50%
Orthodontia (Class D)	50%
Maximum Benefit Amount	
Class A services, age 18 and under (per person per plan year)	No maximum
Class A services for covered persons age 19 and over, and class B and C services for all covered persons (per person per plan year)	$2,000
Class D (per person per lifetime)	$1,500

Vision Insurance

INSURED BY: VSP

All employees enrolled in the medical plan are automatically enrolled in the preventive vision plan.

BENEFIT DESCRIPTION		PREVENTIVE IN-NETWORK COVERAGE	BUY-UP IN-NETWORK COVERAGE	FREQUENCY OF SERVICE
Exam		$10	$10	12 months
Lenses (single, bifocal, trifocal, lenticular)		20% discount on lenses/frames 15% discount lens fitting and evaluation	Covered in full after $25 copay	12 months
Frames			$130 allowance + 20% off balance	12 months
Contacts	**Elective**	Not available	$130 allowance	12 months (in lieu of glasses)

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Employee Rates

All rates are shown as 12-month payroll cycle deductions. Please contact the HR department for alternative payroll cycle calculations.

Laurel Public Schools currently contributes $745 to each employee's benefit package (this could be subject to change following negotiations). The contribution is applied in this order: dental, preventive vision, with any remaining funds applying to medical premiums.

MEDICAL	HDHP $3,200	TRADITIONAL 1500
Single	$679.81	$785.73
Two-Party	$1,015.63	$1,181.38
Employee + Child(ren)	$977.79	$1,135.87
Family	$1,320.97	$1,541.39
Medicare 1-Party	$516.48	$593.18
Medicare 2-Party	$819.58	$951.00

DENTAL	DENTAL
Employee	$33.77*
Employee + Spouse	$67.53
Employee + Child(ren)	$70.91
Employee + Family	$101.29

** All premiums will be reduced by employee dental rate.*

VISION	PREVENTIVE VISION	BUY-UP VISION
Employee	$2.41*	$15.09
Employee + Spouse	$3.85	$24.15
Employee + Child(ren)	$3.93	$24.65
Employee + Family	$6.34	$39.74

** All premiums will be reduced by employee preventive vision rate.*

Life and AD&D Insurance

INSURED BY: MUTUAL OF OMAHA

	COVERAGE
Life Amount	$15,000
AD&D Amount	$15,000
Benefit Reduction	75% at age 65 / 50% at age 70

**Paid for by Laurel Public Schools out of the base benefit.*

Long-Term Disability Insurance

INSURED BY: MUTUAL OF OMAHA

	COVERAGE
Maximum Monthly Benefit	60% of pre-disability earnings, up to $5,000 per month
Elimination Period	90 days
Maximum Benefit Duration	Social Security Normal Retirement Age

**Paid for by Laurel Public Schools out of the base benefit.*

Voluntary Life and AD&D Insurance

INSURED BY: MUTUAL OF OMAHA

BENEFITS	EMPLOYEE	SPOUSE	DEPENDENT
Increments	$10,000	$5,000	$1,000 / $5,000 / $10,000
Guaranteed Issue	$130,000	$50,000	$10,000
Benefit Maximum	$500,000	$250,000 (not to exceed 50% of employee amount)	$10,000 (not to exceed 50% of employee amount)
Age Reduction	33% - 70	33% - 75	19 years; 25 if full-time student

**Employee pays premiums.*

Health Savings Account

ADMINISTRATOR: AMERICAN FIDELITY

	2024
Employee Only	$4,150
Employee +1 or More	$8,300
Age 55+ Catch-up Contribution	$1,000

What is an HSA?

A Health Savings Account is an individually owned, earnings-bearing account to help pay for future qualified medical expenses with tax-free dollars.

Where do I open my HSA?

It is up to you to determine where you would like to open your Health Savings Account. Most banks have the option and if you choose your employer-sponsored program through American Fidelity, you can contribute to your HSA on a pre-tax basis through payroll deductions.

What expenses are eligible for reimbursement?

HSA dollars may be used for qualified medical expenses incurred by the account holder and his/her spouse and IRS dependents. Qualified medical expenses are outlined within IRS Section 213(d) which states that “the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.”

WHO QUALIFIES?

An HSA owner must be enrolled in an HSA-eligible High Deductible Health Plan (HDHP). You cannot be enrolled in Medicare or another plan that is not qualified, or be a tax dependent on someone else’s taxes.

HOW DO I MANAGE MY HSA?

Your HSA is your account and the dollars are your dollars. Since you are the account holder, you manage your HSA. You may choose when to use your HSA dollars or when not to use your HSA dollars. HSA dollars pay for any eligible medical expense.

In addition to qualified medical expenses, the following insurance premiums may be reimbursed from an HSA:

- COBRA premiums
- Health insurance premiums while receiving unemployment benefits
- Qualified long-term care premiums
- Any health insurance premiums paid, other than for a Medicare supplemental policy, by individuals ages 65 and over

Are dental and vision care considered qualified medical expenses under an HSA?

Yes, as long as these are deductible under the current rules. For example, cosmetic procedures, like cosmetic dentistry, would not be considered qualified medical expenses.

Can I use my HSA dollars for non-eligible expenses?

Money withdrawn from an HSA to reimburse non-eligible medical expenses is taxable income to the account holder and is subject to a 20% tax penalty. The exception to this rule is if the account holder is over age 65, disabled, or upon death of the account holder.

When can I start using my HSA dollars?

You can use your HSA dollars immediately following your HSA account activation and once contributions have been made.

When do I contribute to my HSA, and how often?

You, your employer, or others can contribute to your HSA through payroll deductions or as a lump-sum deposit. You can contribute as often as you like, provided you and your employer's total annual contributions do not exceed the contribution limits shown above.

What if I have HSA dollars left in my account at the end of the year?

The money is yours to keep. It will continue to earn interest and will be available for you and your healthcare costs next year. Any dollars left in your HSA at year-end will automatically roll over.

What happens to my HSA dollars if I leave my employer?

The funds are yours to keep! It is your account and you manage it as you see appropriate.

Can I use my money in my account to pay for my dependents' medical expenses?

You can use the money in the account to pay for the medical expenses of yourself, your spouse, and your dependents. You can pay for expenses for your spouse and dependents even if they are not covered by your HDHP.

Who qualifies as a dependent?

A person generally qualifies as your dependent for HSA purposes if you claim them as an exemption on your Federal tax return. Please see IRS publication 502 for exceptions. **www.IRS.gov/Pub/irs-pdf/**.

Can couples establish a "joint" account and both make contributions to the account, including "catch-up" contributions?

"Joint" HSAs are not permitted. Each spouse should consider establishing an account in his or her own name. This allows you to both make catch-up contributions when you are 55 or older.

Flexible Spending Account

ADMINISTRATOR: AMERICAN FIDELITY

Medical Flex Spending Accounts offer the opportunity to pay for known healthcare expenses on a pre-tax basis and are available to those that enroll in the Traditional PPO (not HSA-qualified) plan. The maximum annual contribution you can make to the medical FSA is $3,200. The amount you choose to contribute is an irrevocable annual election without a qualifying event. The annual amount elected is deducted in equal installments via payroll on a pre-tax basis, but the entire amount is available at the beginning of each year. This is a use-it-or-lose-it account, so be sure to estimate your expenses accordingly.

Dependent Care Flex offers the opportunity to pay for qualified daycare on a pre-tax basis in the same fashion as the medical FSA. The maximum annual contribution to this account is $5,000. The purpose is to allow you to pay for qualified child care, elder care, or handicapped dependent care required while you or your spouse are employed. This is also a use-it-or-lose-it plan.

REMINDER: Debit card users are still required by the IRS to submit proof of flex claims.

Visit **www.AmericanFidelity.com/MyMoneyFaster** to learn more about:

- Submitting flex claims online
- Submitting receipts for debit card swipes (IRS requirements)
- Getting your flex reimbursements faster
- All your flex plan options

Voluntary Benefits

ADMINISTRATOR: AMERICAN FIDELITY

American Fidelity offers the following voluntary benefits:

- Short-Term Disability
- Long-Term Disability
  - Only for benefit-eligible employees not covered by the Mutual of Omaha group long-term disability policy
- Long-Term Care
- 403B Annuities
- Cancer
- Accident

Employee Assistance Program (EAP)

ADMINISTRATOR: MUTUAL OF OMAHA

You and your household dependents have access to confidential counseling at no cost to you through the Mutual of Omaha Employee Assistance Program. The program is there to assist you with personal concerns such as stress, anxiety, grief, and relationship or family counseling.

Mutual of Omaha

(800) 316-2796
www.mutualofomaha.com/eap

- 24/7 hotlines
- 3 in-person counseling visits per household per year

Sapphire Resource Connection – Employee Assistance Program (EAP)

Access your EAP by calling a counselor to make your first confidential appointment

For more information, contact your human resource department or call directly for your local counselor: **406-523-7707**

Or call the 24-hour, toll-free help line: **866-767-9511**

You can also visit member services on the web: **www.sr-connection.com**

Staff Wellness Program — Care Solace

ADMINISTRATOR: CARE SOLACE

Dear Staff,

We deeply appreciate the way you support our students and families. We realize when it's you or one of your family members who need support, it might be hard to know where to turn. Inan effort to ease the burden of finding the mental health and substance use services you need,we've partnered with Care Solace, your new central hub of care.

With a network of over 380,000 providers and services, Care Solace will help you find theright help at the right time, 24/7/365. Care Solace's services are available at no cost to you.

How it Works

Call us or visit our website
Our multilingual team is available 24/7/365 tohelp connect you to available providers. Youcan also search the Care Match™ website onyour own anonymously.

Complete a brief screening
Once you connect with us, we'll ask you a fewquick questions so we can better understandwhat you're looking for.

Get matched & book an appointment
Our team will work to find providers matched toyour needs. Once identified, we'll present optionsand can assist with booking your appointment.

If you have a life-threatening emergency, please call 911 or the Suicide and Crisis Lifeline at 988. Care Solace is not an emergency response service or mental health services provider.

Call (888) 515-0595 or go to caresolace.com/laurel.

Contact Information

Questions regarding any of this information can be directed to:

LAUREL PUBLIC SCHOOLS
BENEFIT ADMINISTRATION

Maggie Lowell
lpspayroll@laurel.k12.mt.us

Peggy Pollock
peggy_pollock@laurel.k12.mt.us

LEAVITT GREAT WEST

Cindy Zipperian
cindy-zipperian@leavitt.com

Erin Weenum
erin-weenum@leavitt.com

Confidentiality Disclosure

Notice of Privacy Practices

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- 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:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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, in our office, and on our website.

August 1, 2023

Leavitt Group

Important Legal Notices Affecting Your Health Plan Coverage

Initial and Annual Enrollment Notices – Guide

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

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply.

Newborns Act Disclosure – Federal

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

Notice Of Special Enrollment Rights

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

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

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

- Coverage is lost under Medicaid or a state CHIP program; or
- You or your dependents become eligible for a premium assistance subsidy from the state.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance. To request special enrollment or obtain more information, contact the person listed at the end of this summary.

Wellness Program Disclosure

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at the telephone number listed at the end of this document and we will work with you to develop another way to qualify for the reward.

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's 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, dial 1-877-KIDS NOW, or visit 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)	Health Insurance Premium Payment (HIPP) Program Website: **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://hcpf.colorado.gov/child-health-plan-plus** CHP+ Customer Service: 1.800.359.1991/State Relay 711 Health Insurance Buy-In Program (HIBI): **https://www.mycohibi.com/** 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**
GA HIPP 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.mymaineconnection.gov/benefits/s/?language=en_US** Phone: 1.800.442.6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1.800.977.6740 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

Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**

Phone: 1.800.694.3084

Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – MEDICAID

Website: **http://www.ACCESSNebraska.ne.gov**

Phone: 1.855.632.7633

Lincoln: 402.473.7000

Omaha: 402.595.1178

NEVADA – MEDICAID

Medicaid Website: **http://dhcfp.nv.gov**

Medicaid Phone: 1.800.992.0900

NEW HAMPSHIRE – MEDICAID

Website: **https://www.dhhs.nh.gov/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

Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/**

Medicaid Phone: 609.631.2392

CHIP Website: **http://www.njfamilycare.org/index.html**

CHIP Phone: 1.800.701.0710

NEW YORK – MEDICAID

Website: **https://www.health.ny.gov/health_care/medicaid/**

Phone: 1.800.541.2831

NORTH CAROLINA – MEDICAID

Website: **https://medicaid.ncdhhs.gov/**

Phone: 919.855.4100

NORTH DAKOTA – MEDICAID

Website: **https://www.hhs.nd.gov/healthcare**

Phone: 1.844.854.4825

OKLAHOMA – MEDICAID AND CHIP

Website: **http://www.insureoklahoma.org**

Phone: 1.888.365.3742

OREGON – MEDICAID AND CHIP

Website: **http://healthcare.oregon.gov/Pages/index.aspx**

Phone: 1.800.699.9075

PENNSYLVANIA – MEDICAID AND CHIP	RHODE ISLAND – MEDICAID AND CHIP
Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/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 CAROLINA – MEDICAID	SOUTH DAKOTA – MEDICAID
Website: **https://www.scdhhs.gov** Phone: 1.888.549.0820	Website: **http://dss.sd.gov** Phone: 1.888.828.0059

TEXAS – MEDICAID	UTAH – MEDICAID
Website: **Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services** 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
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 AND CHIP
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)

WINCONSIN – 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 and 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)

General Notice of COBRA Continuation Coverage Rights

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator. Any notice you provide must state the name of the Plan or Plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying even and the date it occurred. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would

have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance

Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Maggie Lowell, Benefits & Compensation Specialist
406-628-3360, ext 3353
lpspayroll@laurel.k12.mt.us