

2026 Employee Benefit Guide

Mounds View PUBLIC SCHOOLS

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Refer to page 30 for more details.

About Your Benefits

Your benefits are an important part of your compensation.

Your benefits

When you think about your total compensation package, don't forget about your benefits. Along with your pay, Mounds View Public Schools has provided a benefit program with real financial value. Your benefits package will improve your life and the lives of your family members. A great deal of time and effort has been invested in designing, funding, and maintaining a quality benefit plan. But you and your family can also play an important role in getting the most from your benefits by making sure that you understand them.

Select your benefits carefully

When possible, you are offered options so that you can select the plan that best fits your needs. To get the most value from your benefits, carefully consider which options are right for you and your family. Because your premiums are generally deducted on a pretax basis, IRS regulations may prohibit you from making enrollment changes until the end of the plan year, unless you experience a family status change. Qualified status changes can include:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a spouse or child
- Unpaid leave of absence
- Change from full-time to part-time or vice versa by you or your spouse
- Commencement or termination of your spouse's employment

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Inside this booklet

This booklet describes your 2026 employee benefits. For each benefit plan, you will find a description of your coverage, as well as information about eligibility, enrollment, costs and contact information. This booklet is intended to provide a summary of each of your benefit plans. Although care was taken to correctly describe these plans, you should consult your Summary of Benefit Coverage that are available on StaffNet on the benefits page for full details.

Eligibility

All active employees working 20 hours or more per week are eligible for benefits the 1st of the month following your board-approved hire date or the 1st if your hire date is the 1st working day of the month.

If you are an active employee and elect coverage for yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and dependent children under age 26. Life insurance covers dependent children to age 19, or 26 if they are a full-time student and primarily supported by you.

Every eligible employee has a one-time eligibility period: 30 days from your board-approved hire date.

Medical Coverage

Administered by HealthPartners

Health Insurance is designed to provide protection for you and your dependents in the event that you require medical care. Remember that you can help to keep your plan costs low. Although you are not required to see a network provider, your expenses will be less when you seek care within the network. Most importantly, make sure you understand your plan so that you can use your medical benefits wisely.

HEALTHPARTNERS OPEN ACCESS $250-$15 COPAY PLAN	
• Traditional open access PPO medical plan • No referrals to see in-network providers	• Deductible: $250 person;$750 family • Out-of-pocket maximum: $2,000 person; $5,000 family • Preventive Care 100% • Office visits and Urgent Care: $15 copay
HEALTHPARTNERS OPEN ACCESS $1,000 DEDUCTIBLE (WITH HRA/VEBA)	
• High Deductible Health Plan (HDHP) • No referrals needed to see in-network providers • Employer-funded HRA/VEBA paired with this plan	• Deductible: $1,000 person; $2,000 family • Out-of-pocket maximum: $2,000 person; $4,000 family • Preventive Care 100% • Office visits and Urgent Care: 80% coverage after deductible

Current medical provider listings are available at **www.healthpartners.com**.

For more information on the District's plans and rate information, log onto StaffNet, click on Human Resources then Benefits.

On the following pages is a brief summary of the key elements of your medical plan choices. Please refer to the benefit plan booklet(s) for specific benefits, limitations and exclusions.

Finding In-network Providers

You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to **www.healthpartners.com** or call **952.883.5000** to find providers in the HealthPartners network.



Medical Coverage

You have a choice of two medical plans through HealthPartners Open Access Network. Review the chart below for the amount you will pay for the medical service listed.

	Open Access $250-$15 Copay Plan		Open Access $1,000 Deductible (With HRA/VEBA)	
	In Network	Out of Network	In Network	Out of Network
Annual Deductible (Individual/Family)	$250/$750	$300/$900	$1,000/$2,000	$2,000/$3,000
Coinsurance	10% after deductible	35% after deductible	20% after deductible	45% after deductible
Annual Out-of-pocket Maximum (Individual/Family)	$2,000/$5,000	$3,500/$8,500	$2,000/$4,000	$5,000/$7,000
Preventive Care	FREE	FREE	FREE	FREE
Office Visits Primary Care Urgent Care Specialist	 $15 copay $15 copay $15 copay	 35% after deductible $15 copay 35% after deductible	 20% after deductible 20% after deductible 20% after deductible	 45% after deductible 20% after deductible 45% after deductible
Emergency Room	$55 copay		20% after deductible	

Terms to Know

- **Copay** - A set dollar amount you pay for a covered health care service, usually when you receive the service.
- **Deductible** - What you pay out of pocket for health care services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered health care services after you reach the deductible. You pay the percentage noted in the table above, and the medical plan pays the rest.
- **Out-of-pocket Maximum** - What you have to pay before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide health care services. In-network providers typically provide services at a lower negotiated rate.

Finding In-network Providers

You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to **www.healthpartners.com** or call **952.883.5000** to find providers in the HealthPartners network.



Medical Premium

Employee Group	Enrollment Tier	Open Access $250-$15 Copay Plan		Open Access $1,000 Deductible (With HRA/VEBA)		
		District's Monthly Contribution	Employee's Monthly Contribution	District's Monthly Contribution	Employee's Monthly Contribution	District's VEBA Contribution (HDHP participants only)
CLERICAL	Single	$861.00	$181.00	$861.00	$0.00	$750.00
	Family	$1,922.00	$980.00	$1,922.00	$480.00	$1,500.00
CLERICAL (Hired BEFORE July 2011)	Single	$1,042.00	$0.00	$861.00	$0.00	$750.00
	Family	$2,322.00	$580.00	$1,922.00	$480.00	$1,500.00
CUSTODIANS	Single	$861.00	$181.00	$861.00	$0.00	$750.00
	Family	$1,922.00	$980.00	$1,922.00	$480.00	$1,500.00
CUSTODIANS (Hired BEFORE July 2011)	Single	$1,042.00	$0.00	$861.00	$0.00	$750.00
	Family	$2,322.00	$580.00	$1,922.00	$480.00	$1,500.00
NUTRITION SERVICES	Single	$861.00	$181.00	$861.00	$0.00	$750.00
	Family	$861.00	$2,041.00	$861.00	$1,541.00	$1,500.00
NUTRITION SERVICES (Hired BEFORE July 2011)	Single	$1,042.00	$0.00	$861.00	$0.00	$750.00
	Family	$1,042.00	$1,860.00	$861.00	$1,541.00	$1,500.00
PARAPROFESSIONAL	Single	$861.00	$181.00	$861.00	$0.00	$750.00
	Family	$1,922.00	$980.00	$1,922.00	$480.00	$1,500.00
PARAPROFESSIONAL (Hired BEFORE July 2011)	Single	$1,042.00	$0.00	$861.00	$0.00	$750.00
	Family	$1,922.00	$980.00	$1,922.00	$480.00	$1,500.00
PRINCIPAL	Single	$1,042.00	$0.00	$861.00	$0.00	$1,000.00
	Family	$2,206.00	$696.00	$1,922.00	$480.00	$1,750.00
NON-AFFILIATED	Single	$1,042.00	$0.00	$861.00	$0.00	$750.00
	Family	$2,206.00	$696.00	$1,922.00	$480.00	$1,500.00
TEACHER	Single	$861.00	$181.00	$861.00	$0.00	$750.00
	Family	$1,922.00	$980.00	$1,922.00	$480.00	$1,500.00
TEACHER (Hired BEFORE July 2011)	Single	$1,042.00	$0.00	$861.00	$0.00	$750.00
	Family	$2,322.00	$580.00	$1,922.00	$480.00	$1,500.00

NOTE: Premiums above are for 1.0 FTE employees. To review premiums for FTE's under 1.0 please refer to your group's benefit summary located on StaffNet on the Benefits page.

Medical Coverage

How the Plans Work

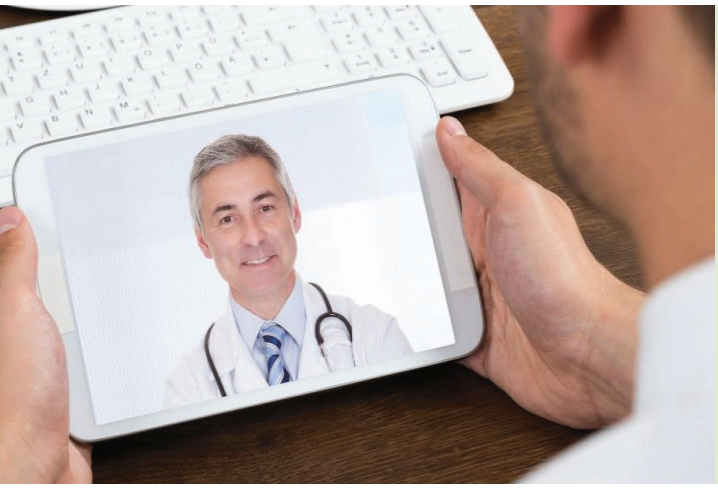
Both plans use the HealthPartners network and cover 100% of the cost for preventive care services like annual physicals and routine immunizations. The way you pay for care is different with each plan.

The **Open Access $250-$15 Copay Plan** has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your annual out-of-pocket maximum.

The **Open Access $1,000 Deductible Plan** coverage is mostly comprised of coinsurance. Coinsurance requires you to cover the full incurred expenses up to your individual deductible. Once you meet your individual deductible, you will then be responsible for only 20% of the cost of additional expenses and the health plan will cover the other 80%. The only services that will cost a set copay under this plan will be prescription medications.



	Open Access $250-$15 Copay Plan	Open Access $1,000 Deductible Plan
Per-paycheck Cost for Coverage	Highest	Lowest
Annual Deductible	Lowest	Highest
Annual Out-of-pocket Maximum	Highest	Lowest
Using the Plan	Pay more with each paycheck and less when you need care	Pay less with each paycheck and more when you need care
Spending Account Options	Health care FSA Dependent care FSA	Health care FSA Dependent care FSA HRA/VEBA



Telemedicine

Getting to the doctor when you're sick is never easy. That's why Mounds View Public Schools offers telemedicine through HealthPartners. You have three options to access online care. Virtuwell , Doctor on Demand and Teladoc.

Virtuwell

3 free visits per family member, then up to $79 per medical visit.
www.Virtuwell.com

Doctor on Demand

Available 24/7. Up to $70 per 15 minute medical visit, behavioral health visit rates will vary.
www.doctorondemand.com

Teladoc

Available 24/7. $89 per medical visit. Behavioral health visit rates may vary.
www.teladochealth.com

Prescription Drug Coverage

Prescription drug coverage through HealthPartners is included with both of our medical plans. Review the chart below for the amount you will pay for the prescription drug service listed.

	Open Access $250-$15 Copay Plan		Open Access $1,000 Deductible (With HRA/VEBA)	
	In Network	Out of Network	In Network	Out of Network
Retail (30-day Supply)				
Generic	$12 copay	35% after deductible	$12 copay	45% after deductible
Preferred	$24 copay	35% after deductible	$35 copay	45% after deductible
Non-preferred	Not Covered	35% after deductible	$50 copay	45% after deductible
Specialty	$24 copay	35% after deductible	20% after deductible	45% after deductible
Mail-order (90-day Supply)				
Generic	$24 copay		$24 copay	
Preferred	$48 copay		$70 copay	
Non-preferred	Not Covered		$100 copay	

Generic Drugs

Generic drugs are FDA-approved, and shown to be just as safe and effective as their more expensive brand-name counterparts. If you choose a brand-name drug when a generic drug is available, you will pay the brand-name copay plus the cost difference between the generic equivalent and the brand-name drug.



Preferred Drugs

HealthPartners regularly reviews the latest prescription drugs on the market and maintains a list of preferred drugs that are clinically effective and not cost-restrictive. These drugs are available at a lower price than those not included on the list, which are called non-preferred drugs.

Specialty Drugs

Specialty drugs are typically used to treat chronic conditions like cancer or multiple sclerosis. These drugs tend to be more expensive and usually require special handling and monitoring. If you take a specialty medication, you could save money by using HealthPartners mail-order pharmacy. You can register for mail-order pharmacy by logging on to **www.healthpartners.com**.

Rx Shopping Tool

The Rx shopping tool is an online prescription cost-saving tool. It helps you find the lowest cost for medicines, based on your current health plan. You'll see a list of their medicines and where you'll find them at the lowest cost. Find other options to save money too, like when a lower price alternative is available.

Visit **healthpartners.com** and log on to your ***my*HealthPartners account**. Once logged on, you'll be able to use the Rx shopping tool.

Medical Insurance Terminology

Unfamiliar terminology can make choosing a medical plan confusing. To help you navigate your benefit options, we have provided the following definitions of common medical insurance terms.

Deductible
A deductible is the amount of money you or your dependents must pay toward a health claim before your insurance plan makes any payments for healthcare services rendered. This amount is an annual amount calculated during the plan year, January through December.

Copays
Copays are a set dollar amount that you pay toward the cost of covered medical services. Typically, you would see a copay for office visits and prescription drugs.

Coinsurance
The amount or percentage that you pay for certain covered healthcare services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Out-of-Pocket Maximum (OOPM)
An out-of-pocket maximum is the maximum amount that an insured will have to pay out of their own pocket for covered expenses under a plan. Deductibles, copays and coinsurance all accumulate towards the OOPM. District plans OOPM calculate on the plan year: January through December. In-network and out-of-network OOPM have separate accumulations.

Explanation of Benefits (EOB)
When you incur an expense, a claim is filed on your behalf with HealthPartners (HP). Once HP processes the claim, you will receive an EOB. The EOB tells you the total amount of the claim, what the provider must "write off" based on their provider contract with HP, what HP paid and what you owe on the claim. The EOB also shows what's accumulated toward your annual OOPM and deductible, if applicable.

Health Reimbursement Arrangement/Voluntary Employees Beneficiary Association (HRA/VEBA)
A tax-free medical expense account funded by the District on your behalf if you enroll in the $1,000 HDHP.

In-Network
In-network refers to providers or healthcare facilities that are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower costs to the insurance companies with which they have contracts.

Out-of-Network (OON)
Services received by a non-network service provider are considered out-of-network. Out-of-network healthcare and plan payments are subject to separate deductibles and OOPM. When you receive care from an OON provider, you may need to submit the claim on your own.

Open Access (OA)
All District-offered plans are OA. Members are not required to select a primary care provider, nor do they need referrals to seek care for specialty needs.

High-Deductible Health Plan (HDHP)
A qualified health plan that gives you more control over your healthcare spending by offering lower monthly premiums in exchange for higher deductibles and out-of-pocket limits.

Summary Plan Description (SPD)
The Summary Plan Description is a summary of the master plan document. You may receive your SPD by contacting HealthPartners' Member Services, your Human Resources team, or by logging into HealthPartners.com.

Formulary Drugs
Formulary drugs are the prescription medications covered under your medical insurance with the maximum plan benefit. If your provider prescribes a non-formulary medication, you will have coverage, but a higher copay will be assessed.

For the HealthPartners plans, please see the complete Formulary Drugs List available at www.healthpartners.com. Under "Services" click on "Pharmacy" then "Search our drug list."

Need Help Selecting your Medical Plan?

It's important to consider your options when selecting your medical plan. Deciding on a plan is a personal decision for you and your family and the "best" option may not always be the most expensive plan. When choosing the plan that's right for you, it's important to think about your total costs:

Fixed costs (annual premium contributions) + Variable costs (out-of-pocket expenses) = Total Costs

Here are a few things to think about when choosing a medical plan...

- Consider the monthly employee contribution. Based on usage, you may save money. Would you prefer to have a higher payroll deduction and lower costs out of pocket, or would you prefer a lower payroll deduction and higher out-of-pocket expenses?
- How do you and your family use your healthcare? Consider the number of office visits you make in an average year, the number and cost of prescription drugs you use, and the number of foreseeable hospital visits you anticipate in the upcoming plan year (pregnancy, chronic conditions, etc.).
- Want more control over your healthcare dollars? With the Open Access $1,000 Deductible plan, the cost of coverage (your monthly premium) is lower, but you generally pay more at the time of service than you would if you were enrolled in the copay plan that the District offers. It's a different way of thinking about the total cost of care. Instead of paying for coverage you might not actually use (in higher premium contributions), a high-deductible health plan lets you pay for only the healthcare services you use.
- The $1,000 deductible plan is paired with an HRA/VEBA contribution. Your HRA/VEBA account is available to reimburse you for expenses incurred on the HDHP.
- Will you be covering dependents that live outside of the HealthPartners' provider area? Your dependents will have access to CIGNA providers and have in-network benefits!
- All employee premium cost sheets are posted on the district website. If you are not full time, the district premium contribution may be prorated per your union labor agreement.



Dental Coverage

Administered by Delta Dental

Dental coverage is designed to provide protection to you and/or your family in the event that you require dental services during the year. Your plan is designed to encourage regular visits to your dentist which is essential to maintaining oral health, and to provide coverage for basic diagnostic and preventive dental needs. Mounds View Public Schools offers dental plans through Delta Dental. Review the chart below for the amount you will pay for the dental services listed.

Your deductibles and annual maximums are accumulated January to December.
For more information on the District's plan and rate information, log onto StaffNet, click on Human Resources then Benefits.

	DELTA DENTAL PPO	DELTA DENTAL PREMIER	OUT OF NETWORK
Annual Deductible (Individual/Family)	None	$50/$100	Benefits are the same as Delta Dental Premier up to the Maximum Allowable fee
Annual Maximum (Per Person)	$1,500	$1,500	
Preventive Care (Routine Cleaning and X-rays, exams)	100% coverage	100% coverage	
Basic Services (Fillings, Basic Root Canals, oral surgery)	80% coverage	80% coverage after deductible	
Major Services (Extractions, Crowns, inlays, onlay(s)	80% coverage	50% coverage after deductible	
Orthodontia	50% coverage	50% coverage after deductible	
Orthodontia Lifetime Maximum (Per covered person)	$1,500	$1,500	

Current dental provider listings are available at www.deltadentalmn.org.

Note: Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Out-of-network dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.

Orthodontic Work in Progress

Delta Dental will cover a member in active orthodontic treatment (bands have been placed) and pay up to the orthodontic maximum, less the total amount of any orthodontic benefit received under any dental coverage which was in force, immediately prior to the member's effective date.



Finding In-network Dentists

You pay less for services when you use a dentist in the Delta Dental network. You can find an in-network dentist by visiting www.deltadentalmn.org or calling **800.448.3815**

Vision Coverage

Administered by EyeMed

Your eye examination and caring for your eyes is important to your overall health. Eye examinations diagnose much more than the need for corrective lenses. An eye examination can uncover more than 30 systemic diseases including hypertension, arteriosclerosis, diabetes, and Graves Disease. This plan allows you to improve your health by saving you money on your eye care purchases.

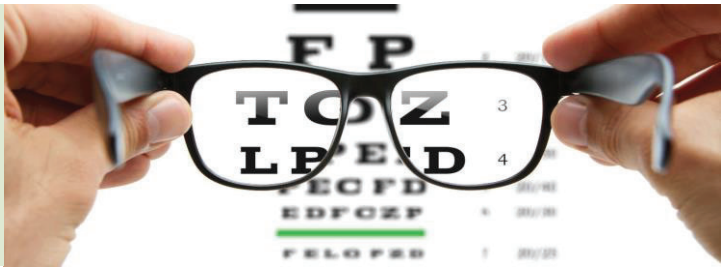
Vision Plan		
	In Network (Member Cost)	Out of Network (Reimbursement)
Eye Exam	$10 Copay ($0 copay at PLUS Providers)	Up to $40
Lenses (Once every 12 months)		
Single Vision	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $70
Lenticular	$25 Copay	Up to $70
Lens Enhancements (Once every 12 months)		
Standard progressive lenses	$80 Copay	Up to $50
Premium progressive lenses	$110-$240 Copay	Up to $50
Frames (Once every 24 months)	$150 allowance ($200 allowance at PLUS Providers) (20% off remaining balance)	Up to $75
Contact Lenses (instead of lens/frames) (Once every 12 months)		
Elective	$150 allowance ($200 allowance at PLUS Providers)	Up to $75
Medically Necessary	No cost	Up to $300

MONTHLY EMPLOYEE RATES	
Employee	$7.47
Family	$19.05

Finding In-network Eye Doctors

Network: INSIGHT

You can find an in-network eye doctor in the EyeMed network by visiting www.eyemed.com or calling 866-804-0982.



Life and Disability Insurance

Administered by The Standard

Life and Accidental Death & Dismemberment Insurance

Basic Life and Accidental Death & Dismemberment is available to employees who meet the eligibility requirements. Benefit level and cost of enrollment will vary based on your FTE status.

What would happen to your family or financial obligations if something happened to you? Life insurance is designed to provide protection for your dependents or to enable your beneficiary to settle your affairs in the event of your death. Regardless of your age, income, or health status, Life Insurance may help secure the future of your survivors.

When you enroll in a Life Insurance policy you need to designate a beneficiary. Since the most current beneficiary designation determines who will receive your benefit, it is important to review this from time to time. You can change your beneficiary at any time in BenTek, the district's benefits platform.

Supplemental Life

Supplemental Life is offered to employees who meet the eligibility requirements as a way to supplement the Basic Life/AD&D coverage. This coverage also provides employees with a way to obtain coverage for their spouse and/or dependent children. You must purchase supplemental Life/AD&D insurance for yourself in order for your dependents to be eligible. Dependent children are eligible to age 26. As an eligible employee under this plan, see your rate sheet for available coverage amounts.

MONTHLY EMPLOYEE SUPPLEMENTAL LIFE RATES	
Age Band	Per $1,000
<25	$0.06
25-29	$0.07
30-34	$0.09
35-39	$0.10
40-44	$0.12
45-49	$0.17
50-54	$0.27
55-59	$0.50
60-64	$0.76
65-69	$1.47
70-74	$2.38
Child	$0.25/family unit
MONTHLY EMPLOYEE SUPPLEMENTAL AD&D RATES	
Per $1,000	
Employee	$0.016
Spouse	$0.031
Child	$0.045

Note: In order to purchase supplemental Life and AD&D coverage for your dependents, you must buy supplemental coverage for yourself.

If you decline supplemental life coverage for yourself and dependents upon hire and decide you want coverage in the future, you will be required to provide

Evidence of Insurability on all amounts of coverage and coverage may be denied. For more specific information regarding life insurance, see your certificates of coverage.

Long-Term Disability

Long-Term Disability coverage is available to employees who meet the eligibility requirements. The cost of enrollment will vary based on your FTE status.

Long-Term Disability coverage provides a reasonable replacement of monthly earnings to an individual who becomes disabled for an extended period of time due to accident or illness. Long-Term Disability coverage provides income when you have been disabled for 90 days or more. Your benefit is 66.67% of your monthly earnings, up to $6,667 per month. This amount may be reduced by other sources of income or disability earnings.



Keep Your Beneficiaries Up to Date

You must use BenTek to designate a beneficiary (the person who will receive the benefit) for your life and AD&D insurance. Make sure to keep this person's information updated so your benefit is paid according to your wishes.

Life Insurance (cont.)

PERA Life Insurance Plan

The Public Employee Retirement Association of Minnesota (PERA) is a member of the National Conference on Public Employee Retirement Systems (NCPERS) Voluntary Life Insurance Plan.

PERA selected the NCPERS program in 1985, because it is a unique plan design particularly well suited for public pension plan members, and it filled member needs not fully addressed by the pension plan. NCPERS is a leading advocate for public pension plans and their members and is dedicated to the protection and improvement of the financial security of public employees.

There are more than 22,000 PERA members/retirees and their dependents insured under this plan, and each year over $2 million in benefits are paid to PERA beneficiaries. The overall NCPERS Plan, of which PERA is a part, insures more than 90,000 members, retirees and dependents and has been providing added security for public employees for over thirty years and has paid over $105 million to beneficiaries of public employees.

Active PERA Defined Benefit Plan members may be eligible for this group term life insurance plan if their employer participates in the program. The coverage may be continued into retirement with deductions taken from the member's monthly pension payment, but the member must be enrolled while an active member. Many employers make payroll deductions available for this program.

Benefit Schedule

$16 Monthly Contribution

MONTHLY SUPPLEMENTAL LIFE RATES				Dependent	
Member's Age at Time of Claim	Group Term Life Insurance	Group AD&D Insurance	Total Benefit for Accidental Death	Group Term Life Insurance	
				Spouse	Child(ren)
<25	$225,000	$100,000	$325,000	$20,000	$4,000 (Age 14 days, but less than 21 years)
25-29	$170,000	$100,000	$270,000	$20,000	
30-39	$100,000	$100,000	$200,000	$20,000	
40-44	$65,000	$100,000	$165,000	$18,000	
45-49	$40,000	$100,000	$140,000	$15,000	
50-54	$30,000	$100,000	$130,000	$10,000	
55-59	$18,000	$100,000	$118,000	$7,000	
60-64	$12,000	$100,000	$112,000	$5,000	
65+	$7,500	$7,500	$15,000	$4,000	
The total cost of coverage for the Member, their Spouse and eligible Children is $16 per month. Payment is made by payroll deduction					

For more information, contact NCPERS at NCPERS@memberbenefits.com or 1 800-525-8056.

Flexible Spending Account (FSA)

Premium Conversion Account— Premiums for your Health/Dental insurance will be automatically deducted from your paycheck before taxes are taken out unless you elect otherwise.

Healthcare Reimbursement FSA

You can set aside up to $3,400 in a Healthcare Reimbursement FSA each year to help pay for out-of-pocket medical, dental and vision expenses for you, your spouse and your dependent child(ren). Below is a brief list of such expenses:

- Deductibles, coinsurance and/or copays under a health, dental or vision plan
- Eye glasses, contact lenses, cleaning and wetting solutions
- Orthodontia expenses
- Lasik eye surgery or radial keratotomy

Federal tax rules define which health expenses are eligible for reimbursement from a Healthcare Reimbursement FSA. For more information, refer to the Flexible Benefit Plan Summary Plan Description on StaffNet. After signing in, click on Human Resources, and then Benefits to find more detailed information.

Orthodontia Expenses: Typically, a portion of an Orthodontia contract (25% to 35%) is for expenses incurred immediately to complete initial orthodontia work. The remainder of the contract balance is divided over the remaining months of treatment. Under some contracts, the remaining months may span over a two- or three-year period. You may only receive reimbursements under your Healthcare Reimbursement FSA for expenses you incur during that plan year.

Dependent Care Reimbursement FSA

You can set aside up to $7,500 (up to $3,750 if you're married and filing separate tax returns) in a Dependent Care Reimbursement FSA each year to help you pay for your eligible dependent care expenses, such as daycare for your child or elder care.

If, in order to maintain employment, you are paying for child care or elder care services, you may be eligible to request reimbursement for some or all of those expenses through this program. Child care or elder care services may qualify for reimbursement if they meet these requirements:

- The child must be under 13 years old or, if older, mentally or physically incapable of caring for himself or herself.
- Must be provided by a facility or caretaker with a registered tax ID number.
- The services may be provided inside or outside your home, but not by someone who is your dependent for income tax purposes, such as an older child, your spouse, or a grandparent who lives with you.

The following illustrates how the Section 125 Flexible Spending Account works.

EXAMPLE: An employee's annual gross pay is $24,000. The employee's portion of premium and additional election to the FSA totals $3,500 for the year.

	Without FSA	With FSA
Gross Pay	$24,000	$24,000
Less Premiums and FSA Contributions	$0	-$3,500
Taxable Income	$24,000	$20,500
Less Taxes (Federal, State and FICA estimated at 30%)	-$7,200	-$6,150
Less Premium and Out-of-Pocket Expenses	-$3,500	-$3,500
Plus Reimbursement from FSA	$0	+$3,500
Take-Home Pay	$13,300	$14,350

*Taxes are illustrated for example purposes only. Reduced Social Security Tax (FICA) may result in less Social Security benefit.

The annual difference of $1,050 shows the value of paying for insurance premiums and other out-of-pocket expenses with pretax dollars. In this example, the employee has an additional $1,050 "in-pocket" throughout the year, versus having paid that amount in taxes.

FSA Plan Participation Requirements & Qualifying Events

Since the premiums and any money set aside in these programs are done so on a pretax basis, the ability to add or drop coverage or change your elections under these programs is limited to either our Annual Open Enrollment Period or due to a change in family status that affects your eligibility for benefits.

*Employees must **make an election each year** and indicate their decision to participate or waive participation under the Healthcare Reimbursement FSA and/or Dependent Care Reimbursement FSA. Prior year elections will not carry over to the next plan year. You may not make any changes to your elections, during the plan year, unless you have a qualified status change.*

Qualified Status Changes may include the following and apply to you, your spouse or your eligible dependent:

- Marriage, divorce, legal separation or annulment.
- Birth or adoption of a child.
- Death of a spouse or child.
- Change in dependent status.
- Change in daycare provider.
- Commencement or termination of your or your spouse's employment.
- Change from full-time to part-time employment or vice versa by you or your spouse.
- A significant change in your or your spouse's health coverage and/or their insurance premium due to your spouse's employment.
- Taking of an unpaid leave of absence by you or your spouse

In most cases, **you have 30 days to notify Human Resources** of a qualified status change.

"Use It or Lose It" Rule

Federal tax laws require that a Section 125 Plan operate on a "use it or lose it" basis. This means that if you do not use the entire amount available for reimbursement under your Healthcare Reimbursement FSA or Dependent Care Reimbursement FSA for a Plan Year, you will forfeit the unused amount and have no further claim to those monies after the Plan Year ends. You have until March 31 each year to submit your claims (incurred during the previous calendar year) for reimbursement.

Our plan includes the $680 carryover provision. Up to $680 remaining in your Healthcare Reimbursement FSA will carryover to be used on expenses incurred during the next plan year. Please note this carryover is not available for the Dependent Care FSA.

Our flex-plan administrator, Benefit Resource (BRI) has online resources, including calculators and information on eligible expenses. Visit on to **www.benefitresource.com** for more information.



Employee Assistance Programs (EAP)

There are times when we all need a little help. An EAP program offers confidential counseling services and resources to help resolve problems that may affect an employee's home or work life. The District offers an employee assistance program for their employees at **no cost**. If you are referred to resources outside of the employee assistance program, there may be a cost for which you are responsible. These programs are completely confidential and available 24 hours a day, 7 days a week.

The Standard and Health Advocate Employee Assistance Program (EAP)

The Standard and Health Advocate Employee Assistance Program is available to all employees and any member of your household. The EAP can help you with the following:

- Child care and elder care
- Alcohol and drug abuse
- Life improvement
- Difficulties in relationships
- Stress and anxiety with work or family
- Depression
- Personal achievement
- Emotional well-being
- Financial and legal concerns
- Grief and loss
- Identity theft and fraud resolution



Take advantage of online resources:

- Information and articles
- Self-assessment tools
- Child/elder care resource tool
- Legal forms
- Financial calculators
- Convenient services
- Monthly work/life webinars

Telephone	Online Resource
Contact the EAP toll-free at: **888.293.6948** **24 hours/day, 7 days/week**	www.members.healthadvocate.com

Mental Health Resources

Your Mental Health is a top priority. There are various ways you can access resources to assist you in a time of need. By prioritizing your mental health, you will have a more engaged, productive, and satisfied life.

HealthPartners

Must be enrolled in a District Medical Plan to access

HealthPartners offers robust mental health resources available to members and patients. But they also know it can be overwhelming to figure out what is right for you. If you need guidance on how to start, contact your primary care provider. A doctor you know and trust is often the person who can best help you get started on your journey. The cost to see a mental health provider through the district medical plan will vary depending on the medical plan you are enrolled in, whether the provider is in HealthPartners' Open Access Network, and the amount that provider charges for a visit.

Doctor On Demand provides access to virtual mental health visits from the comfort of your home. The price will vary depending on which medical plan you are enrolled in and other factors such as if you visit with a psychologist or psychiatrist and how long the visit is. Cost may range from $79-$279.

HealthPartners also offers confidential, NO COST programs to help you build your emotional resilience and cope with life's challenges. For example, their *Healthy Thinking* and *Tackle Stress* well-being activities help you practice thinking positive thoughts and releasing stress in healthy ways. Or, their 4 *Building Emotional Resilience* courses teach you to improve your listening skills, boost your resilience at work and more. All programs give you concrete skills you can use daily.

Not only are these courses free, they're online so you can access them whenever it works for you. Find all of these courses at **healthpartners.com/resilience**.

And if you need more support but aren't sure how your benefits will cover your care, HealthPartners Behavioral health navigators can help. Give them a call at 888-638-8787.

The Standard and Health Advocate Employee Assistance Program (EAP)

Available to all District employees

Through our EAP, you have access to mental health resources at no initial cost to you.

You are able to visit with an in-person provider up to 3 times per instance. Health Advocate will attempt to coordinate with in-network providers (the member's healthcare network) so that if more visits are desired the cost will be in-network with the member's medical insurance. The fee per visit following the 3 covered sessions will be based on the provider and your medical plan.

If you choose to visit with a virtual provider, the first 3 sessions will be at no cost to you. There is a $45 per session fee after the first 3 free sessions. Health Advocate EAP utilizes the virtual platform MyHelp, which is provided by Betterhelp. Betterhelp would be responsible for billing the member directly at the $45 per session fee.

Contact the EAP at www.members.healthadvocate.com or 888.293.6948.

Gallagher Marketplace

Gallagher Marketplace makes it easy for employees to shop non-traditional benefits like home, auto and renters insurance, extended vehicle warranties, legal and identity theft protection, pet insurance and more. You can also access thousands of discounts from car rentals and hotel stays to home goods and electronics through the PerkSpot Program. With no cost or obligations, a Gallagher representative will help you view multiple quotes side-by-side from top carriers offering a variety of payment plans. By shopping through the Gallagher Marketplace, you are getting benefits at better rates than buying a policy on your own. Upon enrollment your monthly premium payments will be made directly to the vendor. Payments are not be taken out of your payroll.

Benefits available for shopping

- Home and Auto Insurance
- Renters, Boat, RV, Motorcycle Insurance
- Vehicle Warranty
- Pet Insurance
- Legal Protection
- Identity Theft Protection
- Perkspot Program

How to get started

1. Visit the Gallagher Marketplace to see your available benefits at **c2mb.ajg.com/gmha/benefits/**
2. Select a product to view more details
3. Click on the partner link to learn more, get a free no obligation quote or apply for coverage
4. Enter “Mounds View Public Schools ” when prompted



Retirement Plans

In 1931, the Minnesota State Legislature established PERA and TRA as a retirement system for county and local government employees (including school district employees). Both of these pension plans are defined benefit plans. The Human Resources Department is able to answer some general questions regarding the plans; however, for specifics, please contact PERA or TRA direct.

PERA

If you are a non-licensed employee, you automatically become a member of PERA when you are hired and meet earning requirements. As a member of the Coordinated Plan, you contribute 6.5% of your salary to PERA (deducted through payroll), and Mounds View Public Schools contributes 7.5% of salary.

Public Employees Retirement Association (PERA)
60 Empire Drive, Suite 200
St. Paul, MN 55103
Phone 651.296.7460
Fax 651.297.2547
www.mnpera.org

TRA

If you are a licensed employee, you automatically become a member of TRA when you are hired and meet earning requirements. As a member, you contribute 8% of your salary to TRA (deducted through payroll), and Mounds View Public Schools contributes 9.81% of salary.

Teachers Retirement Association (TRA)
60 Empire Drive, Suite 400
St. Paul, MN 55103
Phone 651.296.2409
Fax 651.297.5999
www.minnesotatra.org

You begin building your retirement benefit your very first day or employment. “Vesting” simply means you have earned enough service credit to be eligible for a monthly lifetime benefit rather than a refund of your contributions.

- PERA – fully vested after three years of service if hired before July 1, 2010, and five years thereafter
- TRA – fully vested after three years of teaching service if service is after May 15, 1989, and five years if service is between June 30, 1987 and May 15, 1989



Supplemental Retirement Plans

Supplemental Retirement Plan

A financially secure retirement is an important goal for nearly everyone. While retirement can sound like a long way off, starting a supplemental retirement plan early in your career is a sound strategy to provide you with income for your retirement years.

All District employees have three supplemental retirement options available to them. The purpose of these supplemental retirement options is to encourage individuals to save through systematic investments for retirement years. These are voluntary contributions, done through automatic payroll deductions. Be sure to consult with a financial planner for any tax strategies that are associated with these supplement retirement investments.

In addition, an employee may be eligible for a District matching contribution to the tax deferred 403(b) plan. District matching contributions are not available for the 457 deferred compensation plan or the after tax Roth 403(b) plan. For every dollar the employee contributes to the tax deferred 403(b) plan, the District contributes a dollar up to a maximum amount determined by the appropriate collective bargaining agreement. Eligibility and other provisions are also governed by these documents.

Whether you sign up for the District match or employee contributions on your own, the steps to begin participation are as follows:

- Determine which of the options best suits your retirement needs—a tax deferred 403(b) plan, a 457 deferred compensation plan or an after-tax Roth 403(b) plan.
- Contact the company to open an investment account and complete vendor's forms as necessary before submitting paperwork to the payroll department. For a list of vendors including contact information, please visit the benefits page on StaffNet.
- Complete a Mounds View salary reduction form and send it to the Payroll Department at the District Center. For a copy of this form, please visit the benefits pages on StaffNet.
- Any changes to your supplement retirement plan, including changes to the District match, must be made in writing using the salary reduction form. (**This included the election to begin the district match as well**).

If you have any questions about the investment funds, you may contact a representative from the companies on the vendor list. Payroll staff will be able to explain the steps to opening an account, but are not able to provide financial or tax planning advice.
For additional information, please contact our Payroll Department.



Contact Information

Benefit	Group/Policy #	Administrator	Phone	Website or Email
Medical	3050	HealthPartners	952.883.5000 800.883.2177 7:00 a.m. to 6:00 p.m. Monday-Friday	www.healthpartners.com
Dental	50731	Delta Dental	651.406.5916 800.448.3815	www.deltadentalmn.org
Vision	VC-146	EyeMed	866.804.0982	www.eyemed.com
Life and AD&D	164263-A	Standard	800.628.8600	www.standard.com
Long-Term Disability	164263-B	Standard	800.368.1135	www.standard.com
Employee Assistance Program	N/A	Standard	888.293.6948	www.members.healthadvocate.com
Flexible Spending Accounts	N/A	Benefit Resource	888.717.1320 320.457.0058	www.benefitresource.com
Gallagher Marketplace	N/A	Gallagher	N/A	c2mb.ajg.com/gmha/benefits/
Retirement	N/A	Teachers Retirement association (TRA)	651.296.2409	www.minnesotatra.org
Retirement	N/A	Public Employees Retirement association (PERA)	651.296.7460	www.mnpera.org
Retirement	N/A	MN Deferred Comp Plan Health Care Savings Plan	651.296.2761	www.msrs.state.mn.us

Human Resources Department			
Julie Coffey	Executive Director of Human Resources	651.621.6500	Julie.coffey@moundsviewschools.org
Emilee Knapp	Benefits Specialist	651.621.6037	emilee.knapp@moundsviewschools.org

For questions about general benefit coverage, please refer to your benefit certificates/summary plan description (SPD) posted on the District website or your Human Resources Department.



Notices

Women's Health & 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"). 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 the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Open Access $250-$15 Copay Plan (Individual: 10% coinsurance and $250 deductible; Family: 10% coinsurance and $750 deductible)
Plan 2: Open Access $1,000 Deductible (With HRA/VEBA) (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $2,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 651.621.6500 or julie.coffey@moundsviewschools.org.

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

Notices

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 July 31, 2025. 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

Notices

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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) 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/health-care-coverage/ Phone: 1-800-657-3672	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

Notices

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
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 and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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 and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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 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)
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

Notices

To see if any other states have added a premium assistance program since July 31, 2025, 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)

Notices

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Mounds View Public Schools is committed to the privacy of your health information. The administrators of the Mounds View Public Schools Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Julie Coffey - Executive Director of Human Resources at 651.621.6500 or julie.coffey@moundsviewschools.org.

Substance Use Disorder Treatment Records. Substance use disorder treatment records received from programs subject to Part 2, or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the individual or the holder of the record, as provided in Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the Plan would use or disclose the record.

HIPAA Special Enrollment Rights

Mounds View Public Schools Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Mounds View Public Schools Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Julie Coffey - Executive Director of Human Resources at 651.621.6500 or julie.coffey@moundsviewschools.org. -

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notices

Notice of Creditable Coverage

Important Notice from Mounds View Public Schools

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Mounds View Public Schools and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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. **Mounds View Public Schools has determined that the prescription drug coverage offered by the medical plan 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 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Mounds View Public Schools coverage will not be affected. The Choice $15 Copay plan offers the following prescription drug coverage for a 1-month supply: 100% coverage after a $12 copay for Generic Formulary drugs, a $24 copay for Brand Formulary drugs, or No Coverage for Non-Formulary drugs. The Choice $1,000 Deductible plan offers the following prescription drug coverage for a 1-month supply: 100% coverage after a $12 copay for Generic Formulary drugs, a $35 copay for Brand Formulary drugs, or a $50 copay for Non-Formulary drugs. Members may keep this coverage if they elect part D and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Mounds View Public Schools coverage, be aware that you and your dependents may be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Mounds View Public Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Notices

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Mounds View Public Schools changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**January 01, 2026**
Name of Entity/Sender:	**Mounds View Public Schools**
Contact—Position/Office:	**Julie Coffey - Executive Director of Human Resources**
Office Address:	**7250 Victoria St N**
	Shoreview, Minnesota 55126-5800
	United States
Phone Number:	**651.621.6500**

Notices

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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



Notices

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; or
- 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: Julie Coffey.

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.

Second qualifying event extension of 18-month period of continuation coverage

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

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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 period[1] 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

Mounds View Public Schools
Julie Coffey - Executive Director of Human Resources
7250 Victoria St N
Shoreview, Minnesota 55126-5800
United States
651.621.6500

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Notices

Notification of Possible Federal Public Service Loan Forgiveness Eligibility (PSLF)

Minnesota Statutes Section 136A.1792, covers promotion of federal public service loan forgiveness programs. Please be aware that you may be eligible for federal public service loan forgiveness of the remaining balance due on certain federal student loans after you have made 120 qualifying payments on those loans while employed full-time by certain public service employers. For detailed information including how to monitor your progress toward qualifying for PSLF, read the PSLF Questions and Answers documents at StudentAid.gov/ public service or contact your federal loan servicer.

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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 for you 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%[1] 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. [1] [2]

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.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Notices

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 Julie Coffey.

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.

Notices

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 Mounds View Public Schools		4. Employer Identification Number (EIN) 41-6008084
5. Employer address 7250 Victoria St N		6. Employer phone number 651.621.6500
7. City Shoreview	8. State Minnesota	9. ZIP code 55126-5800
10. Who can we contact about employee health coverage at this job? Julie Coffey		
11. Phone number (if different from above)	12. Email address julie.coffey@moundsviewschools.org	

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

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☒ Some employees. Eligible employees are: **Please contact Human Resources for specific eligibility requirements.**

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are: **Please contact Human Resources for specific eligibility requirements.**

  ☐ 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 your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Notices

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

□ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)
□ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

□ Yes (Go to question 15) □ No (STOP and return form to employee)

15. For the lowest cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan?
b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Monthly □ Quarterly □Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
□ Employer won't offer health coverage
□ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan?
b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Monthly □ Quarterly □ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Notes

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The Fine Print

The information contained in this summary should in no way be construed as a promise or guarantee of employment. The company reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this brochure and the actual plan documents or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents available from your Human Resources Office. This benefits enrollment guide highlights recent plan design changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act ("ERISA") as a Summary of Material Modifications and should be kept with your most recent summary plan description.