



2026-2027

Benefit Summary

Glencoe Silver Lake School



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If you 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. Please see page 25-26 for more details.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Benefits Overview

Glencoe Silver Lake School is proud to offer a comprehensive benefits package to eligible, full-time employees who work 30 hours per week. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical).

Benefits Offered

- Medical

Eligibility

You and your dependents are eligible for Glencoe Silver Lake School benefits on your date of hire.

Eligible dependents include your spouse, children under age 26, disabled dependents of any age.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.



Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Phone	Website/Email
Medical	Medica	877-347-0282	www.medica.com
Glencoe—Silver Lake Schools Contact	Trisha Zajicek	320-864-2494	TZajicek@gsi.k12.mn.us
Glencoe—Silver Lake Schools Contact	Pam Teubert	320.864.2497	PTeubert@gsi.k12.mn.us



Benefits at a Glance

Plan	Description
Medical Plan	<p>Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.</p> <p>Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Glencoe Silver Lake School.</p> <p>Glencoe Silver Lake School offers you a choice of three (3) medical plans. With the plans, you may select where you receive your medical services. If you use in-network providers, your costs will be less.</p> <p>The plans you can choose from are the following:</p> <ul style="list-style-type: none"> • \$2,000 Deductible. 20% Coinsurance, \$3,000 OOP • \$4,000 Deductible, 0% Coinsurance, \$4,000 OOP HSA • \$5,000 Deductible, 0% Coinsurance, \$5,000 OOP HSA <p>This comprehensive menu give employees the opportunity to choose the plan that best fits their needs. Glencoe Silver Lake School pays a portion of the plan cost and employee contributions are outlined in this guide.</p>



Medical Benefits

Administered by Medica (Minnesota Healthcare Consortium)



Plan 1		\$2000-20% Choice Passport	
		In-Network	
Lifetime Benefit Maximum		Unlimited	
Annual Deductible		\$2,000 per individual / \$4,000 per family	
Annual Out-of-Pocket Maximum (Includes deductible)		\$3,000 per individual / \$6,000 per family	
Coinsurance		20%	
Doctors Office			
Preventive Visits		100%	
Primary Care Visit		20% after deductible	
Specialist Visit		20% after deductible	
Urgent Care		20% after deductible	
Diagnostic Test (X-rays/tests, blood work)		20% after deductible	
Imaging (CT/PET scans, MRI)		20% after deductible	
Hospital Services			
Emergency Room		20% after deductible	
Inpatient Services		20% after deductible	
Outpatient Surgery		20% after deductible	
Other Services			
Chiropractor Services (Office Visit)		20% after deductible	
Prescription Drugs		Retail - 31 days; Mail Order - 90 days	
Preventive Drug		100%	
Pharmacy Out-of-Pocket		\$750 per individual / \$1,000 per family	
Preferred Generic		\$10 copay per prescription (retail) / \$20 copay per prescription (mail order)	
Preferred Brand		\$25 copay per prescription (retail) / \$50 copay per prescription (mail order)	
Non-Preferred Generic or Brand		\$40 copay per prescription (retail) / \$80 copay per prescription (mail order)	
Specialty Up to a 31-day supply per prescription		Preferred: 20% coinsurance. No more than \$200 copay/prescription Non-preferred: 40% coinsurance	

Medical Benefits

Administered by Medica (Minnesota Healthcare Consortium)



Plan 2		\$4000-0% Choice Passport	
		In-Network	
Lifetime Benefit Maximum		Unlimited	
Annual Deductible		\$4,000 per individual / \$8,000 per family	
Annual Out-of-Pocket Maximum (Includes deductible)		\$4,000 per individual / \$8,000 per family	
Coinsurance		0%	
Doctors Office			
Preventive Visits		100%	
Primary Care Office Visit		0% after deductible	
Specialist Office Visit		0% after deductible	
Urgent Care		0% after deductible	
Diagnostic Test (X-rays/tests, blood work)		0% after deductible	
Imaging (CT/PET scans, MRI)		0% after deductible	
Hospital Services			
Emergency Room		0% after deductible	
Inpatient Services		0% after deductible	
Outpatient Surgery		0% after deductible	
Other Services			
Chiropractor Services (Office Visit)		0% after deductible	
Prescription Drugs		Retail - 31 days; Mail Order - 90 days	
Preventive Drugs		100%	
Preferred Generic		0% after deductible	
Preferred Brand		0% after deductible	
Non-Preferred Generic or Brand		Not Covered	
Specialty Up to a 31-day supply per prescription		Preferred: 0% after deductible Non-preferred: Not Covered	

Medical Benefits

Administered by Medica (Minnesota Healthcare Consortium)



Plan 3		\$5000-0% Choice Passport	
		In-Network	
Lifetime Benefit Maximum		Unlimited	
Annual Deductible		\$5,000 per individual / \$10,000 per family	
Annual Out-of-Pocket Maximum (Includes deductible)		\$5,000 per individual / \$10,000 per family	
Coinsurance		0%	
Doctors Office			
Preventive Visits		100%	
Primary Care Office Visit		0% after deductible	
Specialist Office Visit		0% after deductible	
Urgent Care		0% after deductible	
Diagnostic Test (X-rays/tests, blood work)		0% after deductible	
Imaging (CT/PET scans, MRI)		0% after deductible	
Hospital Services			
Emergency Room		0% after deductible	
Inpatient Services		0% after deductible	
Outpatient Surgery		0% after deductible	
Other Services			
Chiropractor Services (Office Visit)		0% after deductible	
Prescription Drugs		Retail - 31 days; Mail Order - 90 days	
Preventive Drug		100%	
Preferred Generic		0% after deductible	
Preferred Brand		0% after deductible	
Non-Preferred Generic or Brand		Not Covered	
Specialty Up to a 31-day supply per prescription		Preferred: 0% after deductible Non-preferred: Not Covered	

Medca-MHC 19.9% increase -
increase equally distributed

\$2000 single/\$4000 family Deductible Plan 80/20:						Medica MHC 26-27 Rate	Premium Change from 25- 26	Increase Per Check
25-26 Rate								
SINGLE						\$ 1,070.08	\$ 1,283.04	\$ 212.96
FAMILY						\$ 2,891.54	\$ 3,466.96	\$ 575.42
		Plan Cost	District Paid	District Per Check	Employee Cost Per Paycheck	Employee Cost Per MONTH	Employee Cost Per Paycheck	
Local 284 Staff	Single	\$ 1,710.72	\$ 897.33	\$ 448.67	\$ 264.72	\$ 813.39	\$ 406.70	\$ 141.97
September 30 - June 15 Rates 18cks/9mos								
Local 284 Staff	Family	\$ 4,622.61	\$ 897.33	\$ 448.67	\$ 1,479.02	\$ 3,725.28	\$ 1,862.64	\$ 383.62
September 30 - June 15 Rates 18cks/9mos								
Ed MN: GSL Staff	Single	\$ 1,283.04	\$ 673.00	\$ 336.50	\$ 198.54	\$ 610.04	\$ 305.02	\$ 106.48
Ed MN: GSL Staff	Family	\$ 3,466.96	\$ 1,412.00	\$ 706.00	\$ 739.77	\$ 2,054.96	\$ 1,027.48	\$ 287.71
Ed MN: GSL Married **Family		\$ 3,466.96	\$ 1,708.50	\$ 854.25	\$ 591.52	\$ 1,758.46	\$ 879.23	\$ 287.71
Others w/Dist Offer 6000 Annually	Single	\$ 1,283.04	\$ 500.00	\$ 250.00	\$ 285.04	\$ 783.04	\$ 391.52	\$ 106.48
Others w/Dist Offer 6000 Annually	Family	\$ 3,466.96	\$ 500.00	\$ 250.00	\$ 1,195.77	\$ 2,966.96	\$ 1,483.48	\$ 287.71
Others w/Dist Offer 3540 Annually	Single	\$ 1,283.04	\$ 295.00	\$ 147.50	\$ 387.54	\$ 988.04	\$ 494.02	\$ 106.48
Others w/Dist Offer 3540 Annually	Family	\$ 3,466.96	\$ 295.00	\$ 147.50	\$ 1,298.27	\$ 3,171.96	\$ 1,585.98	\$ 287.71
Other - No District Offer	Single	\$ 1,283.04	\$ -	\$ -	\$ 535.04	\$ 1,283.04	\$ 641.52	\$ 106.48
Other - No District Offer	Family	\$ 3,466.96	\$ -	\$ -	\$ 1,445.77	\$ 3,466.96	\$ 1,733.48	\$ 287.71
\$4000 single/\$8000 family Deductible HSA Plan:						Medica MHC 26-27 Rate	Premium Change from 25- 26	Increase Per Check
25-26 Rate								
SINGLE						\$ 932.41	\$ 1,117.96	\$ 185.55
FAMILY						\$ 2,519.54	\$ 3,020.94	\$ 501.40
		Plan Cost	District Paid	District per check	Employee Cost Per Paycheck	Employee Cost Per MONTH	Employee Cost Per Paycheck	
Local 284 Staff	Single	\$ 1,490.61	\$ 897.33	\$ 448.67	\$ 172.94	\$ 593.28	\$ 296.64	\$ 123.70
September 30 - June 15 Rates 18cks/9mos								
Local 284 Staff	Family	\$ 4,027.92	\$ 897.33	\$ 448.67	\$ 1,231.03	\$ 3,130.59	\$ 1,565.30	\$ 334.27
September 30 - June 15 Rates 18cks/9mos								
Ed MN: GSL Staff	Single	\$ 1,117.96	\$ 673.00	\$ 336.50	\$ 129.71	\$ 444.96	\$ 222.48	\$ 92.77
Ed MN: GSL Staff	Family	\$ 3,020.94	\$ 1,412.00	\$ 706.00	\$ 553.77	\$ 1,608.94	\$ 804.47	\$ 250.70
Ed MN: GSL Married **Family		\$ 3,020.94	\$ 1,708.50	\$ 854.25	\$ 405.52	\$ 1,312.44	\$ 656.22	\$ 250.70
Others w/Dist Offer 6000 Annually	Single	\$ 1,117.96	\$ 500.00	\$ 250.00	\$ 216.21	\$ 617.96	\$ 308.98	\$ 92.77
Others w/Dist Offer 6000 Annually	Family	\$ 3,020.94	\$ 500.00	\$ 250.00	\$ 1,009.77	\$ 2,520.94	\$ 1,260.47	\$ 250.70
Others w/Dist Offer 3540 Annually	Single	\$ 1,117.96	\$ 295.00	\$ 147.50	\$ 318.71	\$ 822.96	\$ 411.48	\$ 92.77
Others w/Dist Offer 3540 Annually	Family	\$ 3,020.94	\$ 295.00	\$ 147.50	\$ 1,112.27	\$ 2,725.94	\$ 1,362.97	\$ 250.70
Other - No District Offer	Single	\$ 1,117.96	\$ -	\$ -	\$ 466.21	\$ 1,117.96	\$ 558.98	\$ 92.77
Other - No District Offer	Family	\$ 3,020.94	\$ -	\$ -	\$ 1,259.77	\$ 3,020.94	\$ 1,510.47	\$ 250.70
\$5000 single/\$10,000 family Deductible HSA Plan:						Medica MHC 26-27 Rate	Premium Change from 25- 26	Increase Per Check
25-26 Rate								
SINGLE						\$ 868.67	\$ 1,041.54	\$ 172.87
FAMILY						\$ 2,347.27	\$ 2,814.38	\$ 467.11
		Plan Cost	District Paid	District Per Check	Employee Cost Per Paycheck	Employee Cost Per Month	Employee Cost Per Paycheck	
Local 284 Staff	Single	\$ 1,388.72	\$ 897.33	\$ 448.67	\$ 130.45	\$ 491.39	\$ 245.70	\$ 115.25
Septem ber 30 - June 15 Rates 18 cks/9mos								
Local 284 Staff	Family	\$ 3,752.51	\$ 897.33	\$ 448.67	\$ 1,116.18	\$ 2,855.18	\$ 1,427.59	\$ 311.41
Septem ber 30 - June 15 Rates 18 cks/9mos								
Ed MN: GSL Staff	Single	\$ 1,041.54	\$ 673.00	\$ 336.50	\$ 97.84	\$ 368.54	\$ 184.27	\$ 86.44
Ed MN: GSL Staff	Family	\$ 2,814.38	\$ 1,412.00	\$ 706.00	\$ 467.64	\$ 1,402.38	\$ 701.19	\$ 233.56
Ed MN: GSL Married **Family		\$ 2,814.38	\$ 1,708.50	\$ 854.25	\$ 319.39	\$ 1,105.88	\$ 552.94	\$ 233.56
Others w/Dist Offer 6000 Annually	Single	\$ 1,041.54	\$ 500.00	\$ 250.00	\$ 184.34	\$ 541.54	\$ 270.77	\$ 86.44
Others w/Dist Offer 6000 Annually	Family	\$ 2,814.38	\$ 500.00	\$ 250.00	\$ 923.64	\$ 2,314.38	\$ 1,157.19	\$ 233.56
Others w/Dist Offer 3540 Annually	Single	\$ 1,041.54	\$ 295.00	\$ 147.50	\$ 286.84	\$ 746.54	\$ 373.27	\$ 86.44
Others w/Dist Offer 3540 Annually	Family	\$ 2,814.38	\$ 295.00	\$ 147.50	\$ 1,026.14	\$ 2,519.38	\$ 1,259.69	\$ 233.56
Other - No District Offer	Single	\$ 1,041.54	\$ -	\$ -	\$ 434.34	\$ 1,041.54	\$ 520.77	\$ 86.44
Other - No District Offer	Family	\$ 2,814.38	\$ -	\$ -	\$ 1,173.64	\$ 2,814.38	\$ 1,407.19	\$ 233.56

PLAN DETAILS

Medica Choice® Passport



THE RIGHT CARE FOR YOU. WHEREVER YOU GO.

Medica Choice Passport gives you access to a large, national network with more than one million providers. If you're in your hometown or across the country, you can connect with the providers you know and trust to get the care you need.

An experience you'll love

- Direct access to any primary or specialty care provider in the Medica Choice Passport network without a referral.
- Exceptional network discounts and a member experience that focuses on you.
- Travel with peace of mind. You'll find in-network providers in every corner of the country.
- Access to virtual and behavioral health care options, and wellness extras to help you stay healthy and feel better.



Scan the code above with your phone's camera to find care options in your network. You'll need to select your specific Passport plan (Choice Plus or Options PPO).



Have questions? We're here to help.

Want to know more about your benefits? Have another question? Call Member Services at the number on the back of your Medica ID card (TTY: **711**). You can reach us Monday - Friday, 7 a.m. - 8 p.m. CT (closed 8 - 9 a.m. Thursdays), and Saturday, 9 a.m. - 3 p.m. CT. You can learn more at **Medica.com/FindCare** and select your *Medica Choice Passport* plan (Choice Plus or Options PPO).



Discover a whole-you approach to your health.



Get to know MOBE: Health Coaching at No Cost.

Explore a tool for better well-being. Select individuals with MHC insurance have access to personalized health coaching from MOBE®. If MOBE reaches out, answer the call to jumpstart your journey to better health.

MOBE is made for you.



Talk with a MOBE Guide on the phone to get 1-to-1 support for how you eat, move, sleep, and feel.



Schedule a call with a MOBE Pharmacist to ask questions, check for interactions, and keep your meds at their best.



Download the MOBE Health Guide app to message your Guide, get handpicked resources, and track progress.



Join the MOBE Community on Facebook where you'll find ideas, inspiration, encouragement, and empowerment.



“

It's just really nice for someone to give 100% to me... to invest in my well-being.

—Lisa, MOBE participant

”

MOBE is available at no cost to you as part of your MHC insurance.

Learn more:

Visit mobeforlife.com/mhc or call 844-841-9725.



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Wellness Programs

Your Minnesota Healthcare Consortium health plan includes resources to help you and your employees stay healthy and get support – at no extra cost to employees.

PROGRAM	RESOURCES
Behavioral health resources	<p>Need emotional support and mental health care? Look online, 24/7. Your online member account makes it easy to get the care you need. Explore the resources available to you:</p> <ul style="list-style-type: none"> • Online and in-person therapists, psychiatrists, and more • Clinics close to home • Digital tools that are confidential and tailored to your needs • Support to manage stress, depression, family concerns, and much more <p>Sign in at Medica.com/SignIn for more information.</p>
Medica CallLink®	<p>Trusted answers day or night. Get 24-hour health support from advisors and nurses. Call 1 (800) 962-9497 (TTY: 711).</p>
My Health Rewards by Medica®	<p>Get inspired to make positive changes. Complete activities personalized just for you and earn rewards. Employees can earn up to \$345 in rewards per year and spouse and dependents can earn up to \$225 in rewards per year.</p> <p><i>Employees:</i></p> <ul style="list-style-type: none"> • Download the free Personify Health app from the App Store or Google Play. • Open the app, choose <i>Create Account</i>, and search for and choose <i>Minnesota Healthcare Consortium</i> on the sponsor organization list. • Or go to Medica.com/MHC to create your account online. <p><i>Spouses and dependents ages 18+:</i></p> <ul style="list-style-type: none"> • Download the free Personify Health app from the App Store or Google Play. • Open the app, choose <i>Create Account</i>, and search for <i>Medica</i> on the sponsor organization list. Then choose <i>Medica My Health Rewards</i>. • Or go to Medica.com/MHC to create your account online.
Omada	<p>Personalized support to reach your health goals. Omada’s digital health programs give you the tools and support you need:</p> <ul style="list-style-type: none"> • Omada for Prevention helps you make small changes to lose weight and reduce your risk for diabetes and heart disease. • Omada for Diabetes provides personalized coaching and digital tools to help you improve your blood glucose control. • Omada for Joint & Muscle Health helps you build muscle to prevent aches and pains, and connects you with a licensed physical therapist to help treat current muscle or joint pain, all on your mobile device and schedule. <i>(Available to members enrolled in a Medica Choice® Passport plan).</i> <p>Learn more at OmadaHealth.com/MHC.</p>
Ovia Health	<p>Access live and tailored 1:1 support for every journey. Ovia Health is here to guide and support you through all of life’s moments: From cycle tracking and trying to conceive, to pregnancy, parenting, and managing perimenopause and menopause. Get clinically-backed content and unlimited support from Ovia’s Care Team of health coaches, registered nurses, nutritionists, and certified nurse midwives. Sign in at Medica.com/SignIn to learn more and enroll at no cost.</p>

Plan resources for a healthier you



Your plan includes “extras” that can help you stay healthy, get support, and make the most of your plan – at no extra cost to you.

Stay healthy



Health Rewards Program

Get inspired to make positive changes. Taking steps to improve your health might be easier than you think. Want to lower your stress? Quit smoking? Eat more fruit and veggies? My Health Rewards by Medica® makes it fun — and rewarding. You'll earn rewards as you complete activities personalized just for you. To get started, download the Personify Health app, free in the App Store and on Google Play. Or go to [Medica.com/MHC](https://medica.com/MHC).



Personalized Family and Women's Health Program

Support for your entire parenthood journey.

Ovia Health guides you through your pregnancy, parenting, and reproductive health journey —including trying to conceive and managing menopause. Get clinically-backed content and unlimited support from Ovia's team of health coaches, registered nurses, and certified nurse midwives. Download the Ovia app that's right for you for free from the App Store or Google Play. Enter your health plan information to access all the unique tools and features.



Omada

Personalized support to reach your health goals.

Omada's digital health programs give you the tools and support you need.

• Omada for Prevention

Helps you make small changes to lose weight and reduce your risk for diabetes and heart disease.

• Omada for Diabetes

Provides personalized coaching and digital tools to help you improve your blood glucose control.

• Omada for Joint & Muscle Health

Is a virtual program available to members enrolled in a Medica Choice® Passport plan. It helps you build muscle to prevent aches and pains, and connects you with a licensed physical therapist to help treat current muscle or joint pain, all on your mobile device and schedule.

Learn more at OmadaHealth.com/MHC.



Get support



24-Hour Health Support

Trusted answers any time of day or night. Worried that your stomach bug could be serious? Wondering what to do about that cough that won't go away? The advisors and nurses at Medica CallLink® can help. They're available 24 hours a day, 365 days a year to answer your questions and help you make smart decisions about your health. Just call **1 (800) 962-9497** (TTY users, call **711**).



Behavioral health resources

Need emotional support and mental health care? Look online, 24/7. Your online member account makes it easy to get the care you need. Explore the resources available to you, including:

- Online and in-person therapists, psychiatrists, and more
- Clinics close to home
- Digital tools that are confidential and tailored to your needs
- Support to manage stress, depression, family concerns, and much more

Get started today. Sign in at **Medica.com/SignIn**, then select "Find Care" for more information.

Find information



Your digital one-stop health plan resource

Manage your plan from any device, at any time. With your member account, you can:

- Download and print your ID card and order extras
- Find health care and virtual care providers, clinics, and pharmacies in your network
- Track your medical claims and prescription drugs
- Check medical procedure and drug costs
- See what your plan covers and find out your share of the costs
- Explore wellness programs and behavioral health resources

Create an account at **Medica.com/SignIn** or search for the "myMedica" app in the App Store or Google Play to manage your health plan benefits and improve your health on-the-go.



Questions? We're here to help.

Call Member Services at **1 (877) 347-0282** (TTY: **711**).

Ovia Health



Personalized family and women's health programs

Ovia Health guides you through your entire pregnancy, parenting, and reproductive health journey — including trying to conceive and managing menopause. Get clinically-backed content and unlimited support from Ovia's team of health coaches, registered nurses, and certified nurse midwives within Ovia Health's apps: Ovia and Ovia Parenting.

With Ovia Health apps, you get:

A health assessment and symptom tracking

Get alerts and personal coaching when you need it

Calendars, updates, and checklists

Use a pregnancy calendar, daily baby updates, and a development checklist to track milestones for you and your baby

Health and wellness programs

Learn about infertility, sexual health, menopause, birth planning, preterm delivery, mental health, breastfeeding, and more

Unlimited one-on-one coaching

Send instant messages to registered nurse health coaches

Benefit its library

Learn about your health care benefits from one, easy-to-find place

Career and return-to-work programs

Find coaching and career advice about maternity leave, returning to work, and being a working parent

Dedicated Ovia advocate

Message a trusted, skilled professional to help you navigate your journey and learn about resources

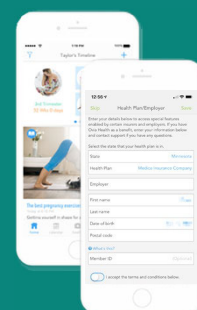


Have questions? We can help.

Call Member Services at the number on the back of your Medica ID card (TTY: **711**).

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oviahealth™



Getting started with Ovia Health

As a Medica member, you can use the exclusive Ovia Health features including one-on-one coaching, reproductive health support, symptom tracking, return-to-work tools, and more. Follow these steps to get started:

1. Download Ovia or Ovia Parenting from the App Store and Google Play.
2. Sign up and choose "I have Ovia Health as a benefit."
3. Enter your state, health plan (Medica), and personal details.
4. Get started!



Calm Health Member Tip Sheet



On-the-go help to boost mental and emotional health

Your plan comes with extra help for mental and emotional health.

Access Calm Health, a mobile app with highly rated tools for mindfulness, sleep, and more, all at no additional cost to you. It's psychologist-designed programs, self-guided steps, and personalized recommendations to help you build life-changing habits.

What you'll get at no additional cost to you:

Help to stress less, sleep better, and live mindfully

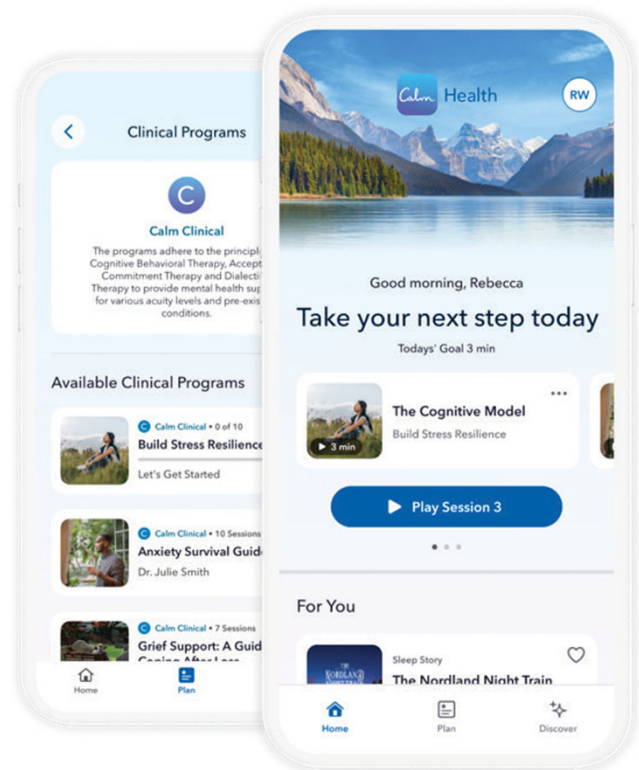
Calm Health's meditations can help you focus and learn to calm your mind. Check out its library of relaxing stories, music, and sounds to help you fall – and stay –asleep.

Programs made by experts, a plan made just for you

You'll get a personalized plan with resources, programs, and tools based on what's important to you. Track your journey as you take steps to sleep better, manage your mood, and more.

Extra care for your overall well-being

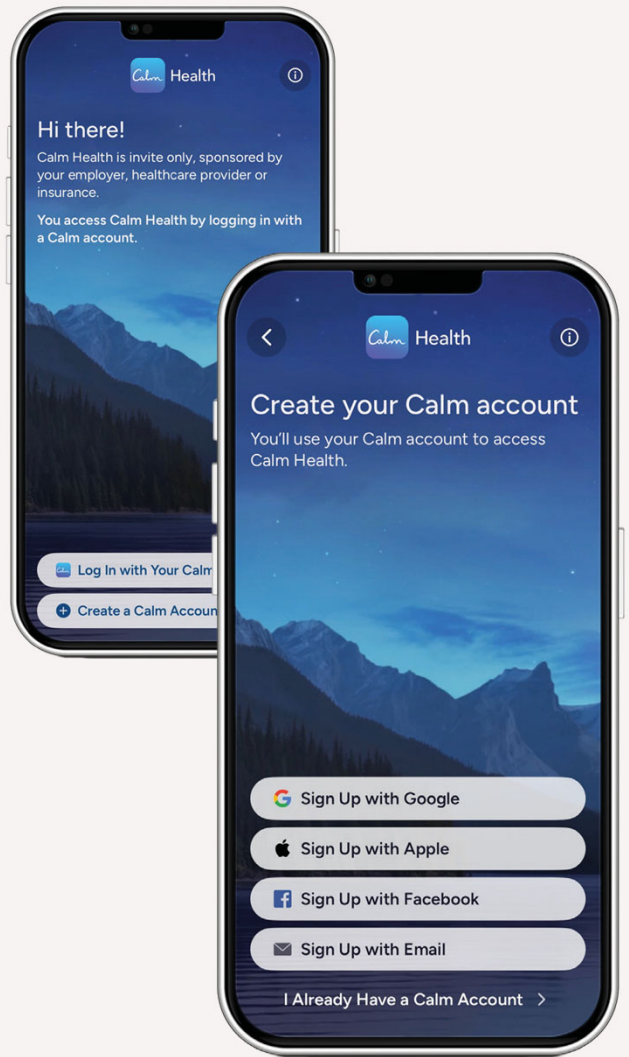
Explore programs that support mental health, chronic illness, and tough life challenges – from anxiety and diabetes to parenting, retirement, or loss of a loved one. It's all in one place.



Start your journey.

How to download and sign up for Calm Health:

1. Scan the QR code or find the Calm Health app in the App Store or Google Play.
2. Select "Create a Calm Account"
3. Sign up with Google, Apple, Facebook, or your email and follow the prompts
4. If asked, enter the access code: **medica**
5. Enter your name and member ID number exactly as they appear on your Medica ID card



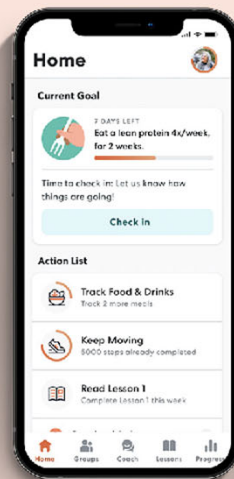
Questions? We're here to help.

Call Member Services at the number on the back of your Medica ID card (TTY: 711).

Calm Health is a mental health wellness product. Calm Health is not intended to diagnose or treat depression, anxiety, or any other disease or condition. Calm Health is not a substitute for care by a physician or other health care provider. Any questions that you may have regarding the diagnosis, care, or treatment of a medical condition should be directed to your physician or health care provider.



Better health, made easier



Whatever 'healthy' means to you, Omada® helps you get there.
All at no cost to you.

What you get with Omada:

- ✓ A plan built around you
- ✓ Dedicated health coach & care team
- ✓ All the smart health devices you need

Do what works for you

We'll help you figure out the healthy habits and routines that work for you—motivation included.

24/7 access to support

From weekly lessons to online community, get all the tools you need to face any challenge head-on.

You decide what 'healthy' means

Try new things you actually enjoy, rather than avoiding foods you "can't eat" or things you "shouldn't do."

The best part? It's covered.

If you or your adult family members are at risk for type 2 diabetes or heart disease or are living with diabetes, and enrolled in our Medica health plan, Minnesota Healthcare Consortium will cover the entire cost of the program.

It only takes 1 minute to get started.

With Omada, there's
a program for you



Weight loss &
overall health



Diabetes

omadahealth.com/mhc



Put an end to aches and pains

Introducing Omada® for Joint & Muscle Health, a virtual physical therapy program that connects you with your very own dedicated licensed physical therapist* to diagnose and treat your aches and pains—all from your smartphone or tablet.

Meet your physical therapist as soon as tomorrow. No driving to appointments, no waiting rooms.

Omada for Joint & Muscle Health is available to Medica members who: are at least 13 years old; are enrolled in a Medica Choice® Passport plan; and live in Iowa, Minnesota, Missouri, North Dakota, South Dakota, or Wisconsin. Your out-of-pocket costs will depend on your plan benefits and the services you access through the program. There's no cost for the prevention program. For a PT consultation and the PT-guided recovery program, each will be covered as an office visit under your plan's physical therapy benefits and applicable copay, deductible, and/or coinsurance rates will apply.

I'm glad the exercises are helping your back.



Join in less than one minute:
omadahealth.com/MHC

Your personal Omada physical therapist will help you:

✓ Reduce pain

Your licensed physical therapist will create a custom treatment plan to treat the source of your pain.

✓ Move better

Increase your strength and flexibility with the free exercise kit included.

✓ Prevent injuries

Your PT tracks your progress during treatment and makes adjustments to ensure your pain improves and stays that way.

✓ Manage stress

Get personalized support and resources from your physical therapist to ensure a healthy mindset.

What do you get as a member?

- ✓ Dedicated licensed physical therapist
- ✓ Personalized treatment plan
- ✓ Unlimited video visits
- ✓ Free exercise kit
- ✓ Tools for a healthy mindset

“ Members love Omada

"I feel so much better than when I started Omada. It's amazing, the improvement in my neck, shoulder, hip and knees! I love that I can hike again without the subsequent knee pain."

- Regena, Omada member

98% of Omada members see improvement in their area of concern and you can too.

Testimonials are based on the member's real experiences and individual results. Results may vary based on individual and demographic factors. We do not claim that these are typical results that members will generally achieve.

*The program features described are specific to the complete version of Omada® for Joint & Muscle Health. Members not experiencing a relevant injury or musculoskeletal condition may instead receive a preventive version of the program, which includes different features and does not include a physical therapist.

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: \$2000-20% Choice Passport (Individual: 20% coinsurance and \$2,000 deductible; Family: 20% coinsurance and \$4,000 deductible)

Plan 2: \$4000-0% Choice Passport (Individual: 0% coinsurance and \$4,000 deductible; Family: 0% coinsurance and \$8,000 deductible)

Plan 3: \$5000-0% Choice Passport (Individual: 0% coinsurance and \$5,000 deductible; Family: 0% coinsurance and \$10,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 320-864-2494 or TZajicek@gsl.k12.mn.us.

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).

Public Service Loan Forgiveness

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.

Premium Assistance Under Medicaid And The Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. 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.mychohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
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: HSHIPPProgram@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://dhcnp.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

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 Rlte 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

To see if any other states have added a premium assistance program since January 31, 2026, 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 3/31/2026)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Glencoe Silver Lake School is committed to the privacy of your health information. The administrators of the Glencoe Silver Lake School 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 Trisha Zajicek – Director of Finance at 320-864-2494 or TZajicek@gsi.k12.mn.us.

HIPAA Special Enrollment Rights

Glencoe Silver Lake School Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Glencoe Silver Lake School 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 Trisha Zajicek – Director of Finance at 320-864-2494 or TZajicek@gsi.k12.mn.us.

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.

Notice of Creditable Coverage

Important Notice from Glencoe Silver Lake School 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 Glencoe Silver Lake School 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. Glencoe Silver Lake School 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 Glencoe Silver Lake School coverage may not be affected. Please contact the Blue Cross and Blue Shield of Minnesota Customer Service department to inquire on eligibility (800.382.2000). With Blue Cross and Blue Shield of Minnesota and Medicare Part D, the primary plan will pay first and if the pharmacy registers can process a second insurance card, the secondary coverage will pay on what is remaining. If the pharmacy cannot process a secondary insurance, then the member can submit a claim to the secondary insurance for the remaining amount.

If you do decide to join a Medicare drug plan and drop your current Glencoe Silver Lake School coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

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

Contact the person listed below for further information. **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 Glencoe Silver Lake School 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:	July 01, 2026
Name of Entity/Sender:	Glencoe Silver Lake School
Contact—Position/Office:	Trisha Zajicek— Director of Finance
Office Address:	1621 16th St E Glencoe, Minnesota 55336-1721 United States
Phone Number:	320-864-2494

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.

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](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.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](https://www.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 Michelle Sander.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Glencoe Silver Lake School		4. Employer Identification Number (EIN) 36-4657882	
5. Employer address 1621 16th St E		6. Employer phone number 320-864-2494	
7. City Glencoe		8. State Minnesota	9. ZIP code 55336-1721
10. Who can we contact about employee health coverage at this job? Trisha Zajicek			
11. Phone number (if different from above)		12. Email address TZajicek@gsl.k12.mn.us	



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.Medica.com or call (952) 945-8000 (TTY: 711) or 1 (800) 952-3455 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call (952) 945-8000 (TTY: 711) or 1 (800) 952-3455 (TTY: 711) to request a copy.

Important Questions		Answers	Why This Matters:
What is the overall deductible?		\$2,000 per person / \$4,000 per family in-network and \$2,000 per person / \$4,000 per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?		Yes. Preventive care, preventive prescriptions, prescription drugs and prenatal care from in-network providers or well child and prenatal care from out-of-network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?		No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?		\$3,000 per person / \$6,000 per family in-network. \$3,000 per person / \$6,000 per family for out-of-network services.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?		Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?		Yes. See www.Medica.com/FindCare or call (952) 945-8000 (TTY: 711) or 1 (800) 952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?		No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

 All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.				
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Primary care: 20% <u>coinsurance</u> Chiropractic: 20% <u>coinsurance</u>	Primary: 30% <u>coinsurance</u> Chiropractic: 30% <u>coinsurance</u>	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	Well child care: 0% <u>coinsurance</u> <u>Deductible</u> does not apply. Other services: 30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab: 20% <u>coinsurance</u> X-ray: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Medica.com/DrugCost1	Generic drugs	Preventive: Designated preventive drugs: No charge. Deductible does not apply. Retail: \$10/prescription. Deductible does not apply. Mail order: \$20/prescription. Deductible does not apply.	30% coinsurance	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed \$25 per retail prescription unit. Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect. ACA preventive drugs covered at no charge. Deductible does not apply.
	Preferred brand drugs	Preventive: Designated preventive drugs: No charge. Deductible does not apply. Retail: \$25/prescription. Deductible does not apply. Mail order: \$50/prescription. Deductible does not apply.	30% coinsurance	
	Non-preferred brand drugs	Preventive: Benefit does not apply. Retail: \$40/prescription. Deductible does not apply. Mail order: \$80/prescription. Deductible does not apply.	30% coinsurance	
	Specialty drugs	Preferred: 20% coinsurance . No more than \$200 copay/prescription Non-Preferred: 40% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket applies.
	Emergency medical transportation	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services



MSI Medica Choice Passport ASO 2000-20%

Coverage Period: Beginning on or after 07/01/2026
Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	None
	Inpatient services	20% coinsurance	30% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	Prenatal care: No charge. Deductible does not apply. Postnatal care: 20% coinsurance	Prenatal care: 0% coinsurance . Deductible does not apply. Postnatal care: 30% coinsurance	Cost sharing does not apply to in-network preventive services . Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
	Home health care	20% coinsurance	30% coinsurance	120 visits in-network and 60 visits out-of-network, per member per year.
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	30% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Habitatation services	20% coinsurance	30% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	20% coinsurance	30% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	20% coinsurance	30% coinsurance	None
	Hospice services	20% coinsurance	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	30% coinsurance	None
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan .
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan .

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services.)	
<ul style="list-style-type: none"> • Acupuncture exceeding 15 visits per member per year for in-network and out-of-network acupuncture services combined • Bariatric surgery • Chiropractic care exceeding 15 visits per member per year out-of-network • Cosmetic surgery 	<ul style="list-style-type: none"> • Dental care (Adult) • Dental check-up • Glasses • Infertility treatment • Long-term care • Private-duty nursing • Routine foot care except for some conditions • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • Hearing aids 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult)

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.Medica.com or call (952) 945-8000 (TTY: 711) or 1 (800) 952-3455 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call (952) 945-8000 (TTY: 711) or 1 (800) 952-3455 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$4,000 per person / \$8,000 per family in-network and \$4,000 per person / \$8,000 per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, preventive prescriptions and prenatal care from in-network providers or well child and prenatal care from out-of-network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$4,000 per person / \$8,000 per family in-network. \$4,000 per person / \$8,000 per family for out-of-network services.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/FindCare or call (952) 945-8000 (TTY: 711) or 1 (800) 952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary care: 0% <u>coinsurance</u> Chiropractic: 0% <u>coinsurance</u>	Primary: 0% <u>coinsurance</u> Chiropractic: 0% <u>coinsurance</u>	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	<u>Specialist</u> visit	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	Well child care: 0% <u>coinsurance</u> <u>Deductible</u> does not apply. Other services: 0% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab: 0% <u>coinsurance</u> X-ray: 0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.Medica.com/DrugCost1	Generic drugs	Preventive: Designated preventive drugs: No charge. <u>Deductible</u> does not apply. Retail: 0% <u>coinsurance</u> Mail order: 0% <u>coinsurance</u>	0% <u>coinsurance</u>	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed \$25 per retail prescription unit.
	Preferred brand drugs	Preventive: Designated preventive drugs: No charge. <u>Deductible</u> does not apply. Retail: 0% <u>coinsurance</u> Mail order: 0% <u>coinsurance</u>	0% <u>coinsurance</u>	Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect. ACA preventive drugs covered at no charge. <u>Deductible</u> does not apply.
	Non-preferred brand drugs	Preventive: Benefit does not apply. Retail: 0% <u>coinsurance</u> Mail order: 0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	<u>Specialty drugs</u>	Preferred: 0% <u>coinsurance</u> Non-Preferred: 0% <u>coinsurance</u>	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. Amounts reimbursed or paid by a <u>provider</u> or manufacturer, on your behalf for a product or service, will not apply toward your cost share.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	None
	Physician/surgeon fees	0% coinsurance	0% coinsurance	None
	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
If you need immediate medical attention	Emergency medical transportation	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	None
	Physician/surgeon fees	0% coinsurance	0% coinsurance	None
	Outpatient services	0% coinsurance	0% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	0% coinsurance	0% coinsurance	Residential treatment is covered as part of inpatient services.
	Office visits	No charge. Deductible does not apply.	Prenatal care: 0% coinsurance . Deductible does not apply. Postnatal care: 0% coinsurance	Cost sharing does not apply to in-network preventive services . Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	
If you are pregnant	Childbirth/delivery facility services	0% coinsurance	0% coinsurance	

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services



MSI Medica Choice Passport ASO 4000-0% HRA

Coverage Period: Beginning on or after 07/01/2026

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	120 visits in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	0% coinsurance	0% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	0% coinsurance	0% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	0% coinsurance	0% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	0% coinsurance	0% coinsurance	None
	Hospice services	No charge. Deductible does not apply.	0% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	0% coinsurance	None
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan .
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan .

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services .)	
<ul style="list-style-type: none"> • Acupuncture exceeding 15 visits per member per year for in-network and out-of-network acupuncture services combined • Bariatric surgery • Chiropractic care exceeding 15 visits per member per year out-of-network • Cosmetic surgery 	<ul style="list-style-type: none"> • Dental care (Adult) • Dental check-up • Glasses • Infertility treatment • Long-term care • Private-duty nursing • Routine foot care except for some conditions • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • Hearing aids 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult)



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.Medica.com or call (952) 945-8000 (TTY: 711) or 1 (800) 952-3455 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call (952) 945-8000 (TTY: 711) or 1 (800) 952-3455 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$5,000 per person / \$10,000 per family in-network and \$5,000 per person / \$10,000 per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and prenatal care from in-network providers or well child and prenatal care from out-of-network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$5,000 per person / \$10,000 per family in-network. \$5,000 per person / \$10,000 per family for out-of-network services.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/FindCare or call (952) 945-8000 (TTY: 711) or 1 (800) 952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary care: 0% <u>coinsurance</u> Chiropractic: 0% <u>coinsurance</u>	Primary: 0% <u>coinsurance</u> Chiropractic: 0% <u>coinsurance</u>	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	<u>Specialist visit</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	Well child care: 0% <u>coinsurance</u> <u>Deductible</u> does not apply. Other services: 0% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab: 0% <u>coinsurance</u> X-ray: 0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.Medica.com/DrugCost2	Generic drugs	Preventive: Designated preventive drugs: No charge. <u>Deductible</u> does not apply. Retail: 0% <u>coinsurance</u> Mail order: 0% <u>coinsurance</u>	0% <u>coinsurance</u>	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed \$25 per retail prescription unit.
	Preferred brand drugs	Preventive: Designated preventive drugs: No charge. <u>Deductible</u> does not apply. Retail: 0% <u>coinsurance</u> Mail order: 0% <u>coinsurance</u>	0% <u>coinsurance</u>	Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect.
	Non-preferred brand drugs	Preventive: Benefit does not apply. Retail: 0% <u>coinsurance</u> Mail order: 0% <u>coinsurance</u>	0% <u>coinsurance</u>	ACA preventive drugs covered at no charge. <u>Deductible</u> does not apply.
	<u>Specialty drugs</u>	Preferred: 0% <u>coinsurance</u> Non-Preferred: 0% <u>coinsurance</u>	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. Amounts reimbursed or paid by a <u>provider</u> or manufacturer, on your behalf for a product or service, will not apply toward your cost share.



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	None
	Physician/surgeon fees	0% coinsurance	0% coinsurance	None
	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
If you need immediate medical attention	Emergency medical transportation	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	None
	Physician/surgeon fees	0% coinsurance	0% coinsurance	None
	Outpatient services	0% coinsurance	0% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	0% coinsurance	0% coinsurance	Residential treatment is covered as part of inpatient services.
	Office visits	Prenatal care: No charge. Deductible does not apply. Postnatal care: 0% coinsurance	Prenatal care: 0% coinsurance . Deductible does not apply. Postnatal care: 0% coinsurance	Cost sharing does not apply to in-network preventive services . Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	
If you are pregnant	Childbirth/delivery facility services	0% coinsurance	0% coinsurance	

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services



MSI Medica Choice Passport ASO 5000-0% HSA

Coverage Period: Beginning on or after 07/01/2026

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	120 visits in-network and 60 visits out-of-network per member per year.
	Rehabilitation services	0% coinsurance	0% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	0% coinsurance	0% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	0% coinsurance	0% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	0% coinsurance	0% coinsurance	None
If your child needs dental or eye care	Hospice services	0% coinsurance	0% coinsurance	None
	Children's eye exam	No charge. Deductible does not apply.	0% coinsurance	None
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan .
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan .

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services .)	
<ul style="list-style-type: none">Acupuncture exceeding 15 visits per member per year for in-network and out-of-network acupuncture services combinedBariatric surgeryChiropractic care exceeding 15 visits per member per year out-of-networkCosmetic surgery	<ul style="list-style-type: none">Dental care (Adult)Dental check-upGlassesInfertility treatmentLong-term carePrivate-duty nursingRoutine foot care except for some conditionsWeight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none">Hearing aids	<ul style="list-style-type: none">Non-emergency care when traveling outside the U.S.Routine eye care (Adult)

Medica Commercial Preventive Drug List

(1/1/2026)

Certain health plans provide a specific benefit for preventive outpatient drugs that are considered maintenance drugs used to treat common disease states. Plan terms vary and members should consult their benefit plan documents to determine whether they have coverage for preventive maintenance drugs and, if so, with lower or no member cost sharing. Some strengths or dosage forms, noted with an *, may not be included in the Preventive Drug List, regardless of their appearance in this document. Certain products or categories may not be covered or may be subject to utilization management edits such as step therapy, prior authorization, or quantity limits. Please check with your plan provider should you have any questions about coverage. If your benefit includes mail order, please note that some drugs and supplies may not be available through this service.

ANTIPLATELETS

ANTICOAGULANTS

ELIQUIS
enoxaparin
fondaparinux
rivaroxaban*
warfarin*
XARELTO

PLATELET AGGREGATION INHIBITORS

BRILINTA
clopidogrel
dipyridamole
prasugrel
Ticagrelor

CORONARY ARTERY DISEASE

ANTHYPERLIPIDEMICS

atorvastatin
cholestyramine
colesevelam*
colestipol
ezetimibe
fenofibrate*
fenofibric acid*
fluvastatin
gemfibrozil
icosapent ethyl
lovastatin
niacin ext-rel
omega-3 acid ethyl esters
pravastatin
rosuvastatin

simvastatin

COMBINATION ANTIHYPERLIPIDEMICS

amlodipine/atorvastatin
ezetimibe/simvastatin

DIABETES

BLOOD GLUCOSE MONITORS

ACCU-CHEK GUIDE BLOOD GLUCOSE METER
CONTOUR NEXT BLOOD GLUCOSE METER

INJECTABLE DIABETES AGENTS

HUMULIN R* (U-500 Only)
INSULIN DEGLUDEC
INSULIN GLARGINE-YFGN
liraglutide
NOVOLIN N, R, 70/30
NOVOLOG
OZEMPIC
RYBELSUS
SEMGLEE (YFGN)
TOUJEO
TRESIBA
TRULICITY
VICTOZA

ORAL DIABETES AGENTS

acarbose
FARXIGA
glimepiride
glipizide
glipizide ext-rel
glipizide/metformin
glyburide
glyburide/metformin

GLYXAMBI

JANUMET

JANUMET XR

JANUVIA

JARDIANCE

metformin

metformin ext-rel

miglitol

nateglinide

pioglitazone

pioglitazone/glimepiride

pioglitazone/metformin

repaglinide

SYNJARDY XR

SYNJARY

TRIJARDY XR

XIGDUO XR

SUPPLIES

INSULIN SYRINGES, AND NEEDLES –
BD/Embecka Products

HYPERTENSION

ACE INHIBITORS/ ANGIOTENSIN II RECEPTOR ANTAGONISTS AND COMBINATION AGENTS

amlodipine/benazepril
benazepril
benazepril/hydrochlorothiazide
candesartan
candesartan/hydrochlorothiazide
captopril
captopril/hydrochlorothiazide
enalapril

Please note: This list represents brand products in CAPS, branded generics in upper- and lowercase, and generic products in lowercase.

Please check with your plan provider should you have any questions about coverage. Additional medications may be included in this list from time to time in compliance with Affordable Care Act requirements and/or U.S. Internal Revenue Service (IRS) guidance. This list includes medications considered preventive by the IRS; it may not include all preventive medications.

enalapril/hydrochlorothiazide
 eprosartan
 fosinopril
 fosinopril/hydrochlorothiazide
 irbesartan
 irbesartan/hydrochlorothiazide
 lisinopril
 lisinopril/hydrochlorothiazide
 losartan
 losartan/hydrochlorothiazide
 moexipril
 perindopril
 quinapril
 quinapril/hydrochlorothiazide
 ramipril
 telmisartan
 telmisartan/hydrochlorothiazide
 trandolapril
 trandolapril/verapamil ext-rel
 valsartan
 valsartan/hydrochlorothiazide

BETA-BLOCKERS AND COMBINATION AGENTS

acebutolol
 atenolol
 atenolol/chlorthalidone
 betaxolol
 bisoprolol
 bisoprolol/hydrochlorothiazide
 carvedilol
 labetalol
 metoprolol
 metoprolol succinate ext-rel
 metoprolol/hydrochlorothiazide
 nadolol
 pindolol
 propranolol
 propranolol ext-rel
 propranolol/hydrochlorothiazide
 timolol maleate

CALCIUM CHANNEL BLOCKERS AND COMBINATION AGENTS

amiloride/hydrochlorothiazide
 amlodipine

diltiazem - select products
 felodipine ext-rel
 isradipine
 nicardipine
 nisoldipine ext-rel
 verapamil
 verapamil ext-rel

DIURETICS

chlorthalidone
 furosemide
 hydrochlorothiazide
 indapamide
 spironolactone
 spironolactone/hydrochlorothiazide
 torsemide
 triamterene/hydrochlorothiazide

OTHER ANTIHYPERTENSIVE AGENTS

amlodipine/valsartan/hydrochlorothiazide
 clonidine
 clonidine transdermal
 guanfacine
 hydralazine
 methyl dopa
 Minoxidil

MENTAL HEALTH

ANTIDEPRESSANTS

amitriptyline
 amoxapine
 bupropion
 bupropion ext-rel
 citalopram
 clomipramine
 desipramine
 desvenlafaxine succinate ext-rel
 doxepin
 duloxetine delayed-rel
 escitalopram
 fluoxetine
 fluoxetine delayed-rel
 fluvoxamine
 imipramine HCl

imipramine pamoate
 mirtazapine
 nortriptyline
 paroxetine HCl
 paroxetine HCl ext-rel
 phenelzine
 protriptyline
 sertraline
 tranlycypromine
 trazodone
 trimipramine
 venlafaxine
 venlafaxine ext-rel

ANTIPSYCHOTICS

ariprazole
 chlorpromazine
 clozapine
 fluphenazine
 haloperidol
 loxapine
 lurasidone
 olanzapine
 olanzapine orally disintegrating tabs
 paliperidone
 perphenazine
 quetiapine
 quetiapine ext-rel

risperidone
 thioridazine
 thiothixene
 trifluoperazine
 ziprasidone

OSTEOPOROSIS

BONE RESORPTION THERAPY

alendronate
 ibandronate
 raloxifene
 risedronate

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RESPIRATORY DISORDERS**RESPIRATORY AGENTS**

ADVAIR HFA
albuterol inhaler*
albuterol nebulizer solution
ARNUITY
ASMANEX HFA
ASMANEX TWISTHALER
BREO ELLIPTA
BREYNA
budesonide inhalation suspension
budesonide-formoterol
cromolyn sodium
DULERA
fluticasone/salmeterol diskus*
INCRUSE ELLIPTA
ipratropium nebulizer solution
ipratropium/albuterol nebulizer solution
levalbuterol nebulizer solution
montelukast
QVAR REDHALER
SPIRIVA
SPIRIVA RESPIMAT
SYMBICORT
theophylline
tiotropium
zafirlukast

Over-the-counter (OTC) products require a prescription. Coverage may vary by plan.

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

This benefit summary prepared by



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