

YOUR BENEFITS

Medical • VEBA • Dental • Vision • Disability • Life • and more!



OUR MISSION

Columbia Heights Public Schools
Creating worlds of opportunity for each and every learner
"All Belong, All Succeed"



2026 Benefit Guide

Prepared For:



Our Employees Are Our Most Valuable Asset

At Columbia Heights ISD 13 we are committed to offering a comprehensive employee benefits program that helps our employees stay healthy, feel secure, and maintain a work-life balance.

Stay Healthy

- Medical, Dental, Vision
- Flexible Spending Accounts
- Health Savings Accounts

Feeling Secure

- Disability Insurance
- Retirement Benefits
- Life and Accidental Death & Dismemberment Insurance

Work-Life Balance

- Employee Assistance Program
- Discretionary and Sick Time

Contact Information for Benefit Vendors

Page:

- [5] Health Insurance
Minnesota Health Consortium (MHC)
1-877-347-0282
www.medica.com/SignIn
- [27] Dental Insurance
Delta Dental
800-448-3815
www.deltadentalmn.org
- [30] Vision Insurance
VSP
800-877-7195
www.vsp.com
- [33] Long Term Disability (LTD) Insurance
Madison National Life
800-627-3660 ext. 1232
www.nisbenefits.com
- [35] Life Insurance
Madison National Life
800-627-3660 ext. 1232
www.nisbenefits.com
- [38] Accidental Death and Dismemberment (AD&D) Insurance
Zurich
800-627-3660 ext. 1232
www.nisbenefits.com



Contact Information for Benefit Vendors

Page:

[40] Flexible Spending Account (FSA) & VEBA
MedSurety
952-303-5700
www.medsurety.com

[46] COBRA
See section

[48] Employee Assistance Program (EAP)
TELUS Health
866-451-5465
www.niseap.com

[52] Identity Theft Protection
IDX Identity Theft Recovery
800-939-4170
www.idx.us

[54] Group Legal
Legal Shield
866-288-5229
www.legalshield.com/info/legalplan

[59] Voluntary Benefits
Aflac
800-992-3522
www.aflac.com



Health Insurance



Who is Eligible and When

- Active Employees who work at least 30 hours per week (.75 to 1.00 FTE)
- Any employees working less than 30 hours per week (< .75 FTE), please refer to your employment contract
- Coverage effective on date of hire

Carrier Name and Website Address

- Medica
- www.medica.com/SignIn
- **Mobile app available:** your one-stop health plan resource. Instant access to health plan data, download your ID card to your mobile wallet, check claim status, find providers and clinics, and access documents and forms.

Prescription and Pharmacy Solutions

- Express Scripts
- On or after your effective date with Medica, register on the Express Scripts website or through your member website at www.medica.com/SignIn
- 1-800-263-2398
- **Mobile app available:** Express Scripts mobile app allows you to check drug costs, find pharmacies, view prescription history, print forms and ID cards, and receive medication related alerts.

MEDICAL PLAN SUMMARIES

 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 ?	No deductible in-network. \$300 per person / \$900 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. In-network services and 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 ?	\$2,500 per person / \$2,500 per family in-network. \$3,750 per person / \$7,500 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 .

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: \$20 copay /visit Chiropractic: \$20 copay /visit	Primary: 50% coinsurance Chiropractic: 50% coinsurance	In-network primary care visits provided at an outpatient facility may be subject to coinsurance . Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	\$20 copay /visit	50% coinsurance	In-network specialist visits provided at an outpatient facility may be subject to coinsurance .
	Preventive care/screening/immunization	No charge	Well child care: 0% coinsurance Deductible does not apply. Other services: 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: No charge X-ray: No charge	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance	None

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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	Retail: \$8/prescription Mail order: \$16/prescription	50% 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.
	Preferred brand drugs	Retail: \$16/prescription Mail order: \$32/prescription	50% coinsurance	
	Non-preferred brand drugs	Retail: \$32/prescription Mail order: \$64/prescription	50% coinsurance	
	Specialty drugs	Preferred: 20% coinsurance . No more than \$200/prescription. Non-Preferred: 40% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$20 copay /visit	50% coinsurance	None
	Physician/surgeon fees	\$20 copay /visit	50% coinsurance	None
If you need immediate medical attention	Emergency room care	No charge	0% coinsurance . Deductible does not apply.	In-network out-of-pocket applies.
	Emergency medical transportation	No charge	0% coinsurance . Deductible does not apply.	In-network out-of-pocket applies.
	Urgent care	\$20 copay /visit	\$20 copay /visit. Deductible does not apply.	In-network out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% coinsurance	None
	Physician/surgeon fees	No charge	50% coinsurance	None

If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay /visit	50% coinsurance	Other outpatient services include intensive outpatient programs, diagnostic evaluations and psychological testing. *May require prior authorization.
	Inpatient services	No charge	50% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge	Prenatal care: 0% coinsurance . Deductible does not apply. Postnatal care: 50% 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	No charge	50% coinsurance	
	Childbirth/delivery facility services	No charge	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	120 visits in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	\$20 copay /visit	50% 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	\$20 copay /visit	50% 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	No charge	50% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	No charge	50% coinsurance	None
	Hospice services	No charge	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% 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 .

MEDICAL PLAN SUMMARIES

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 ?	\$1,200 per person / \$2,400 per family in-network and \$1,800 per person / \$3,600 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 from in-network providers and 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?	\$1,200 per person / \$2,400 per family in-network. \$3,500 per person / \$7,000 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% coinsurance Chiropractic: 0% coinsurance	Primary: 20% coinsurance Chiropractic: 20% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	0% coinsurance	20% coinsurance	None
	Preventive care/screening/immunization	No charge. Deductible does not apply.	Well child care: 0% coinsurance . Deductible does not apply. Other services: 20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 0% coinsurance X-ray: 0% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	None
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	Retail: 0% coinsurance Mail order: 0% coinsurance	20% 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	Retail: 0% coinsurance Mail order: 0% coinsurance	20% coinsurance	
	Non-preferred brand drugs	Retail: 0% coinsurance Mail order: 0% coinsurance	20% coinsurance	
	Specialty drugs	Preferred: 0% coinsurance Non-Preferred: 0% coinsurance	Not covered	

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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	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	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	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	20% coinsurance	None
	Inpatient services	0% coinsurance	20% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge. Deductible does not apply.	Prenatal care: 0% coinsurance . Deductible does not apply. Postnatal care: 20% 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	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	

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	20% coinsurance	120 visits in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	0% coinsurance	20% 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	20% 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	20% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	0% coinsurance	20% coinsurance	None
	Hospice services	0% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	20% 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 .

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Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,850 per person / \$3,700 per family in-network and \$2,850 per person / \$5,700 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 from in-network providers and 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 ?	\$1,850 per person / \$3,700 per family in-network. \$4,300 per person / \$8,600 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 .

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% coinsurance Chiropractic: 0% coinsurance	Primary: 20% coinsurance Chiropractic: 20% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	0% coinsurance	20% coinsurance	None
	Preventive care/screening/immunization	No charge. Deductible does not apply.	Well child care: 0% coinsurance . Deductible does not apply. Other services: 20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 0% coinsurance X-ray: 0% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	None
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	Retail: 0% coinsurance Mail order: 0% coinsurance	20% 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.
	Preferred brand drugs	Retail: 0% coinsurance Mail order: 0% coinsurance	20% coinsurance	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	Retail: 0% coinsurance Mail order: 0% coinsurance	20% coinsurance	ACA preventive drugs covered at no charge. Deductible does not apply.
	Specialty drugs	Preferred: 0% coinsurance Non-Preferred: 0% coinsurance	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. Amounts reimbursed or paid by a provider or manufacturer, on your behalf for a product or service, will not apply toward your cost share.

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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	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	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	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	20% coinsurance	None
	Inpatient services	0% coinsurance	20% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge. Deductible does not apply.	Prenatal care: 0% coinsurance . Deductible does not apply. Postnatal care: 20% 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	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	

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		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	20% coinsurance	120 visits in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	0% coinsurance	20% 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	20% 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	20% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	0% coinsurance	20% coinsurance	None
	Hospice services	0% coinsurance	20% coinsurance	None
	Children's eye exam	No charge. Deductible does not apply.	20% coinsurance	None
If your child needs dental or eye care	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 .

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 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 ?	\$6,350 per person / \$12,700 per family in-network and \$9,550 per person / \$19,100 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?	\$6,350 per person / \$12,700 per family in-network. \$14,350 per person / \$28,700 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% coinsurance Chiropractic: 0% coinsurance	Primary: 20% coinsurance Chiropractic: 20% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	0% coinsurance	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	Well child care: 0% coinsurance Deductible does not apply. Other services: 20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 0% coinsurance X-ray: 0% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Medica.com/DrugCost2	Generic drugs	Retail: 0% coinsurance Mail order: 0% coinsurance	20% 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.
	Preferred brand drugs	Retail: 0% coinsurance Mail order: 0% coinsurance	20% coinsurance	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	Retail: 0% coinsurance Mail order: 0% coinsurance	20% coinsurance	ACA preventive drugs covered at no charge. Deductible does not apply.
	Specialty drugs	Preferred: 0% coinsurance Non-Preferred: 0% coinsurance	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. Amounts reimbursed or paid by a provider or manufacturer, on your behalf for a product or service, will not apply toward your cost share.

MEDICAL PLAN SUMMARIES

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	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	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	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	20% coinsurance	None
	Inpatient services	0% coinsurance	20% 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: 0% coinsurance	Prenatal care: 0% coinsurance . Deductible does not apply. Postnatal care: 20% 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	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	

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	20% coinsurance	120 visits in-network and 60 visits out-of-network per member per year.
	Rehabilitation services	0% coinsurance	20% 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	20% 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	20% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	0% coinsurance	20% coinsurance	None
	Hospice services	0% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	20% 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 .

MEDICAL PLAN SUMMARIES

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 .)		
• 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	• 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.)		
• Abortion • Hearing aids	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602 or the U.S. Department Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: your [plan](#) administrator or you may contact Medica at 1-800-952-3455.

Does this Plan Provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this Plan Meet the Minimum Value Standard? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1 (800) 952-3455** (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1 (800) 952-3455** (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1 (800) 952-3455** (TTY: 711).

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' **1 (800) 952-3455** (TTY: 711).

VEBA (Voluntary Employees' Beneficiary Association)

The VEBA is a tax-free healthcare savings plan, funded entirely by the district. You pay no taxes on the balance, the interest earned, or on any withdrawals. It can help you pay for qualified medical, dental, and vision expenses now or in the future. It may also be used to pay for health insurance premiums when you retire. You may visit the MedSurety website at www.medsurety.com for a list of eligible expenses.

When you enroll in one of the three High Deductible medical plans through the district, you are automatically enrolled in a VEBA account. VEBA accounts are funded twice per year –2 months' worth of contributions in July, and the remaining amount in September. If your employment terminates before September 1st you will not receive the second deposit. Any expenses that exceed your available balance will be out-of-pocket for you. If you are newly hired midyear, you will receive one lump sum deposit of the pro-rated amount (based on your hire date) in your first year only.

The amount the district contributes depends on the plan and tier level you choose. As of the 2026-2027 school year, below are the contribution amounts:

	July Contribution	September Contribution
VEBA 1200/2400 Single plan	\$200	\$1,000
VEBA 1200/2400 Family plan	\$400	\$2,000
VEBA 1850/3700 Single plan	\$200	\$1,000
VEBA 1850/3700 Family plan	\$400	\$2,000
Minimum Value Single plan	\$489.00	\$2,445.00
Minimum Value Family plan	\$973.80	\$4,869.00

Funds are available as you receive them. If you are in need of all funds in July due to extenuating circumstances, a VEBA Hardship Request form may be turned in to the Benefits Office for review. Contact Heather Lynch in Human Resources to request a form. Hardship forms will not be accepted after the last teaching day of the school year.

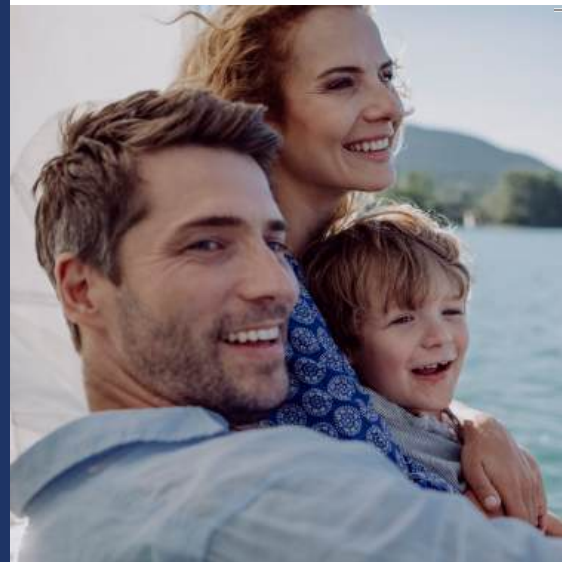
You will receive a debit card from MedSurety in order to access the funds. You can use the card at any provider's office or merchant that accepts the card. Please refer to the Benefits page on the district website to view a Frequently Asked Questions document for more information on how to use the card. If you are also enrolled in a Flexible Spending Account (FSA), you can use the same card for both. Funds will be depleted from the FSA first before VEBA funds are accessed.

The VEBA earns interest and can also be used for investments. A beneficiary can be named on the account and is strongly recommended. Beneficiaries can be designated on the MedSurety website by logging in to your account, or by filling out a Beneficiary Designation form.

Questions regarding your VEBA account can be referred to MedSurety at 952-303-5700 or to Heather Lynch in Human Resources.

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).

Support resources

Minnesota Healthcare Consortium

Resources for Group Leaders and Employees

Resources for Group Leaders

Medica Employer Service Center

The Medica Employer Service Center is the place to call when you have questions about benefits, claims and more as a Group Leader. Our team of senior-level professionals has the training, knowledge and resources to quickly:

- Clarify benefit information.
- Check claims and provider status.
- Order new ID cards and other materials.
- Get questions answered about the Medica member website.

Call the Employer Service Center at **1 (800) 936-6880**. We're available 8 a.m. - 5 p.m. CST Monday, Tuesday, Wednesday and Friday. And 9 a.m. - 5 p.m. on Thursdays. Or email MedicaServiceCenter@Medica.com.

Businessolver (formerly Capstone)

Businessolver can help with membership eligibility and enrollment questions, billing issues, demographic corrections and reset administrator passwords for Benefitsolver. Call **1 (515) 453-8723** or email mhc@businessolver.com.

Benefitsolver Portal

Access your employer monthly invoice on your Benefitsolver portal. View reports including: employee census, new hires, cobra qualifying events, address changes, employee termination, and many more. Visit Benefitsolver.com.

Resources for Employees

Medica Customer Service

When your employees have questions about their health plan benefits, we're here to help. Employees can call Customer Service to get answers to their questions:

- Is my doctor in the network?
- Do I have a copay? A deductible? Coinsurance?
- Has my claim been paid?
- How much will my prescription cost?
- What health and wellness programs are available?

Call Customer Service at **1-877-347-0282** (TTY: **711**). We're available 7 a.m.- 8 p.m. Monday - Friday and 9 a.m.-3 p.m. on Saturdays.

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://www.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](https://www.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**).

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	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: • 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 Sign in at Medica.com/SignIn for more information.
Medica CallLink®	Trusted answers day or night. Get 24-hour health support from advisors and nurses. Call 1 (800) 962-9497 (TTY: 711).
My Health Rewards by Medica®	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. <i>Employees:</i> • 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. <i>Spouses and dependents ages 18+:</i> • 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	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 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> Learn more at OmadaHealth.com/MHC.
Ovia Health	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.

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 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**).



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

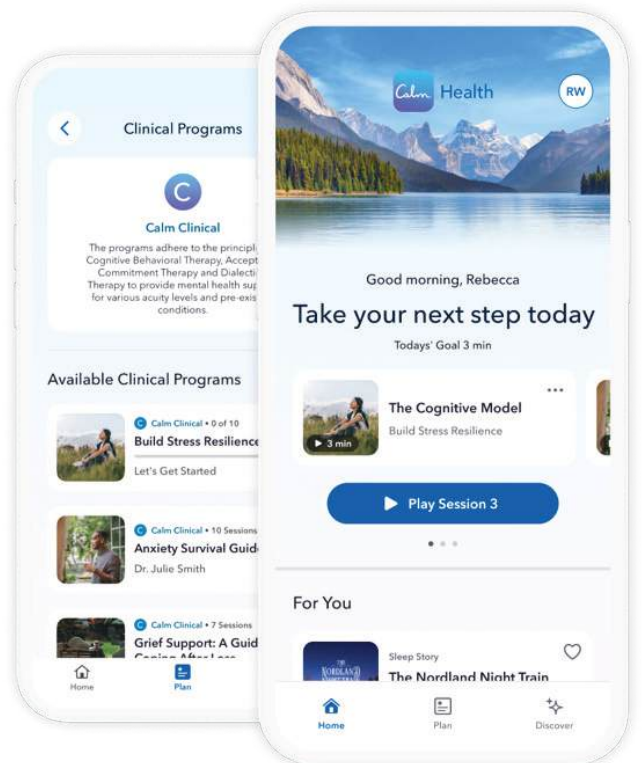
Calm Health's meditations can help you focus and learn to calm your mind. Check out its library of relaxing stories, music, and sounds to help you fall – and stay – asleep.

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

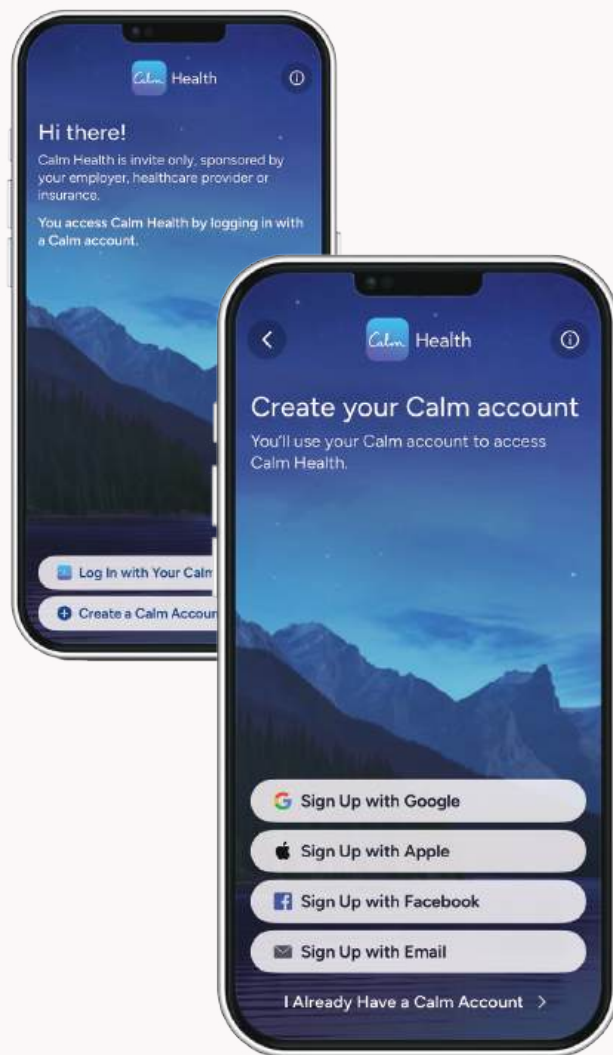
Explore programs that support mental health, chronic illness, and tough life challenges – from anxiety and diabetes to parenting, retirement, or loss of a loved one. It's all in one place.



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



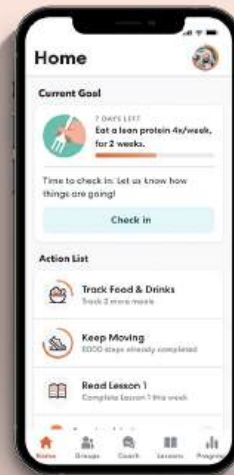
Questions? We're here to help.

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.

omadahealth.com/mhc

With Omada, there's
a program for you



Weight loss &
overall health



Diabetes





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.



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.

Dental Insurance



Who is Eligible and When

- Active Employees who work at least 30 hours per week (.75 to 1.00 FTE)
- Any employees working less than 30 hours per week (< .75 FTE), please refer to your employment contract
- Coverage effective on date of hire

Carrier Name and Website Address

- Delta Dental
- www.deltadentalmn.org

Delta Dental of Minnesota

**Delta Dental PPOSM &
Delta Dental Premier[®]**

Columbia Heights Schools ISD # 13

Group # 4107

Plan Benefit Highlights			
Network(s)	Delta Dental PPO SM	Delta Dental Premier [®]	Non-Participating*
Coverage Year Plan Maximum Per person	\$1,500		
Lifetime Ortho Maximum Per eligible covered person	\$1,000		
Deductible Per person / per family per calendar year <i>No deductible for diagnostic and preventive services or orthodontics</i>	\$50/person \$100/family		
Eligible Dependents	Spouse Dependent children up to age 26		

Covered Services	Dental Benefit Plan Coverage		
Diagnostic & Preventive Services Exams Cleanings X-rays Fluoride treatments Space Maintainers	100%	100%	100%
Basic Services Emergency treatment for relief of pain Amalgam restorations (silver fillings) Composite resin restorations (white fillings) on anterior (front) teeth Composite resin restorations (white fillings) on posterior (back) teeth shall be limited to the allowances for amalgam fillings Denture adjustments and repairs Bridge repair	80%	80%	80%
Endodontics Root canal therapy on permanent teeth Pulpotomies on primary teeth for dependent children	80%	80%	80%
Periodontics Surgical/Nonsurgical periodontics	80%	80%	80%
Oral Surgery Surgical/Nonsurgical extractions All other covered oral surgery	80%	80%	80%
Major Restorative Crowns Crown repair	80%	80%	80%
Prosthetics + Dentures (full and partial) Bridges	50%	50%	50%
Orthodontics Treatment for the prevention/ correction of malocclusion <i>Available for dependent children only, ages 8-18</i>	50%	50%	50%



Prefer to Speak to Someone
Contact customer service

Toll Free: 1-800-448-3815
Local: 651-406-5901
Monday –Friday: 7am-7pm c.s.t.

Visit Our Website
DeltaDentalMN.org

Administered by: Delta Dental of Minnesota
 P.O. Box 59238
 Minneapolis, MN 55459

DDMN.4.12.16.1



Vision Insurance



Who is Eligible and When

- Active Employees who work at least 30 hours per week (.75 to 1.00 FTE)
- Any employees working less than 30 hours per week (< .75 FTE), please refer to your employment contract
- Coverage effective on date of hire

Carrier Name and Website Address

- VSP
- www.vsp.com

	VSP Choice Materials Only Plan	VSP Choice Plan
Exams	N/A	• WellVision Exam covered every 12 months after \$10 Copay
Essential Medical Eye Care	- Retinal imaging for eligible members with diabetes - Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more - Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	
Frame Allowance	• \$100 Frame allowance every 24 months	• \$120 Frame allowance every 24 months
Lenses	- Single vision, lined bifocal, or lined trifocal lenses for adults after \$10 copay for glasses - Impact-resistant lenses for dependent children covered after copay for glasses every 12 months	- Single vision, lined bifocal, or lined trifocal lenses for adults after \$25 copay for glasses - Impact-resistant lenses for dependent children covered after copay for glasses every 24 months
Lens Enhancements	- Standard Progressive lenses covered in-full 30% average savings on lens enhancements, like Scratch-resistant coating and UV protection	- Standard Progressive lenses covered in-full 30% average savings on lens enhancements, like Scratch-resistant coating and UV protection
Contact Lens Allowance (instead of glasses)	\$140 allowance for contacts lenses and Copay up to \$60 for contacts lens exam (fitting and evaluation) every 12 months	\$120 allowance for contacts lenses and Copay up to \$60 for contacts lens exam (fitting and evaluation) every 12 months
Retinal Imaging	N/A	• No more than a \$39 Copay on routine retinal screening as an enhancement to a WellVision Exam

Get the Savings You Need.

Visit vsp.com/offers to see all the Exclusive Member Extras. Take advantage of exclusive special offers for you and the whole family! Save on your favorite frame brands and contact lenses and get discounts on wellness products and services that make your life easier.

\$20

Enjoy an Extra \$20 on Featured Frame Brands.

40%

Save up to 40% on popular lens enhancements*.

Like vision loss, hearing loss can have a huge impact on your quality of life. [TruHearing](#)® makes hearing aids affordable by providing exclusive savings to all VSP Vision Care members.

As a VSP member, you can save up to 60% on a pair of hearing aids with TruHearing. Your dependents and even extended family members are eligible too.

Learn more about this VSP Exclusive Member Extras at truhearing.com/vsp.

TruHearing™

Long Term Disability Insurance



Who is Eligible and When

- Active employees who work at least 30 hours per week (.75 FTE) are automatically enrolled.
- For employees who work less than 30 hours per week (< .75 FTE), please refer to your employment contract.

Carrier Name and Website Address

- Madison National Life
- www.nisbenefits.com

Class	Class Title/Eligibility	Effective Date	Elimination Period (period of total)	Benefit %
3	Non-Affiliated Professionals and Licensed Employees	Date of Hire	60 consecutive working days	66-2/3
4	Non-Licensed Employees	Date of Hire	60 consecutive working days	66-2/3
6	Part-Time Teachers who work at least .50 FTE but less than .75 FTE	Date of Hire	60 consecutive working days	66-2/3

Life Insurance



Who is Eligible and When

- Active employees who work at least 30 hours per week (.75 FTE) are automatically enrolled.
- For employees who work less than 30 hours per week (< .75 FTE), please refer to your employment contract.

Carrier Name and Website Address

- Madison National Life
- www.nisbenefits.com

Class #	Class Title/Eligibility	Basic Life	Supplemental Life
3	Licensed Employees	\$50,000	\$10,000 increments to a maximum of \$300,000
4	Clerical, Custodial, Professional Group A, Education Assistants, and Food Service Employees	\$50,000	\$10,000 increments to a maximum of \$300,000
9	Non-Licensed Community Education and Professional Group B Employees	\$25,000	\$10,000 increments to a maximum of \$300,000
11	Part-Time Certified Employees who work at least .50 FTE but less than .75 FTE	\$50,000	\$10,000 increments to a maximum of \$300,000

Dependent Life

Dependent Life Child Limiting Age: 21 or 25 if full-time student	Spouse: \$10,000 Child: \$2,000 Infant: \$200
Basic Life coverage: Supplemental & Dependent Life:	Paid by the district (Classes 3, 4, 9) Pro-rated for class 11 Paid by the employee
Minnesota Continuation:	18 Month Minnesota Continuation Applies to Life
Minnesota Continuation and Retirement:	MN Continuation applies to retiring employees. MN Continuation runs concurrently with any other Retiree coverage.
Conversion Provision:	Included – must apply within 31 days
Beneficiary Administration:	Employers should request regular updates and maintain for their own records. Employees should also maintain a copy of the most recent beneficiary form for their records.

Employee & Spouse Rates Per \$1,000	
Under 30	\$.06
30-34	\$.07
35-39	\$.09
40-44	\$.13
45-49	\$.18
50-54	\$.29
55-59	\$.59
60-64	\$.81
65-69	\$1.75
70+	\$4.50

Dependent Life	\$2.97 per unit
Child Life	\$.123 per \$1,000

Voluntary AD&D



Accidental Death and Dismemberment

Policy: Zurich – GTU4380634

Policy: Zurich – GTU4380634

Class Title and Eligibility	Option 1: Employee Only	Option 2: Family
All Other Eligible Employees	\$50,000 increments to a maximum of the lesser of 10 times annual salary or \$500,000	\$50,000 increments to a maximum of the lesser of 10 times annual salary or \$500,000

Benefit Amounts for Dependents	Spouse/Domestic Partner only: 50% of Employee Election Dependent Child(ren) only: 15% Employee Election Spouse/Domestic Partner and Child(ren): • 40% Employee Election for Spouse/Domestic Partner • 10% Employee Election for Child(ren)
Reduction Schedule	Class 01: Benefits do not reduce Class 02: At age 70 for the insured employee benefits will reduce to 65%; at age 75 benefits will reduce to 45%; at age 80 benefits will reduce to 30% and at age 85 and over benefits will
Employee Premium Contribution	Premium is paid by the Employee.
Coma Benefit	Included
Exposure and Disappearance Coverage	Included
Travel Assistance Coverage	Included

Flexible Spending Account



Who is Eligible and When

All eligible employees working a minimum of 30 hours per week.

Benefits You Receive:

Flexible Spending Accounts (FSAs) provide you with an important tax advantage that can help you pay for health care and dependent care expenses on a pre-tax basis. By estimating your family's health care and dependent care costs for the next year, you can lower your taxable income and save money.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses with a prescription not covered by their insurance plan with pre-tax dollars. The current limit on salary reduction contributions to a health FSA offered under a cafeteria plan is \$3,400 and is applicable to both grandfathered and non-grandfathered health FSAs. This limit is indexed for cost-of-living adjustments in subsequent years. Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations, and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives

FSA

FACT SHEET

Using a Flexible Spending Account (FSA) is a smart way to make the most of your benefit dollars. You can use before-tax dollars from your FSA to reimburse yourself for eligible out-of-pocket medical and dependent care expenses. This means tax savings and increased take-home pay, all with the convenience of a prepaid benefits card.

What is a Flexible Savings Account (FSA)?

With an FSA, you can elect to contribute up to **\$3,400** annually in 2026 (IRS limit). Your elected amount is deducted from your paycheck in equal installments throughout the year until you reach your specified annual maximum.

The portion of your pay that goes into an FSA is not considered taxable income, giving you immediate tax savings. You can use FSA funds during the plan year to pay for qualified medical or dependent care expenses.

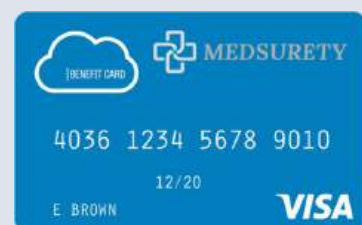
- A Healthcare FSA allows reimbursement for qualifying out-of-pocket medical expenses.
- A Limited Purpose FSA is designed to work alongside a qualified High-Deductible Health Plan (HDHP) and Health Savings Account (HSA). It only allows reimbursement for eligible vision and dental expenses.

With all FSA account types, you'll have access to a secure, user-friendly web portal where you can track your account balance, view claim history, and submit reimbursement requests.

You'll receive a convenient **prepaid benefits card** to easily pay for eligible services and products not covered by your health insurance. Payments are automatically withdrawn from your account—just swipe and go. Most expenses are validated through the transaction, but some may require a receipt in accordance with IRS rules. When needed, receipts can be easily uploaded through the consumer portal or mobile app.

With an FSA, you can:

- **Enjoy significant tax savings** with pre-tax contributions and tax-free reimbursements for qualified plan expenses.
- **Quickly and easily access funds** using the prepaid benefits card at point of sale, or request direct deposit to your bank account through the online portal or mobile app.
- **Reduce paperwork and filing hassles** by using your prepaid benefits card.
- **Enjoy secure, 24/7 access** to your account through the convenient Consumer Portal.
- **Manage your FSA "on the go"** with our easy-to-use mobile app.
- **Easily file claims online** (when required) and let the system automatically determine approval based on eligibility and available funds.
- **Stay up to date on** balances and required actions with automated email alerts and convenient messages on the portal and mobile home page.
- **Get one-click answers** to benefits questions.
- **Use It or Roll It Over.** Now, up to \$680 of your unused Healthcare FSA balance can be carried over into the next plan year instead of being lost. This makes enrolling in an FSA less risky and gives you more flexibility to spend your FSA funds on necessary out-of-pocket healthcare expenses—without the pressure of last-minute, unnecessary spending at year-end.



IS AN FSA RIGHT FOR ME?

An FSA is a great way to pay for expenses with pre-tax dollars.

A Healthcare FSA could save you money if you or your dependents:

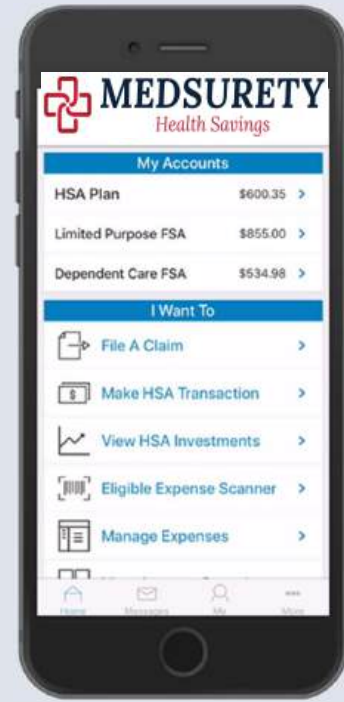
- Have out-of-pocket expenses like co-pays, coinsurance, or deductibles for health, prescription, dental, or vision plans
- Have a health condition that requires the purchase of prescription medications on an ongoing basis
- Wear glasses or contact lenses, or are planning LASIK surgery
- Need orthodontia care (such as braces) or have dental expenses not covered by your insurance

PLAN AHEAD

Before enrolling, you'll need to decide how much to contribute to your account(s). Take time to estimate your anticipated eligible medical and dependent care expenses for the 2026 calendar year, but know that you don't have to worry about losing unused funds (up to \$680).

Be sure to estimate carefully. Any unused funds in your Healthcare FSA may be forfeited if not spent within the allotted grace period. Expenses incurred during the grace period are applied to your prior year's balance before current year funds are used.

With the convenience of a mobile device, you can see your available balance anywhere, anytime as well as file claims and upload receipts.



*The amount you save in taxes with a Flexible Spending Account will vary depending on the amount you set aside in the account; your annual earnings; whether or not you pay Social Security taxes; the number of exemptions and deductions you claim on your tax return; your tax bracket and your state and local tax regulations. Check with your tax advisor for information on how participation will affect your tax savings.



Dependent Care FSA

The Dependent Care FSA lets employees use pre-tax dollars toward qualified dependent care such as caring for children under the age of 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is \$7,500 (or \$3,750 if married and filing separately) per calendar year. This is a use it or lose it account, no carry over to future years. This is a tax savings benefit. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Dependent Care FSA

Contribution Limits & IRS

The IRS sets the maximum dollar amount you can elect and contribute to a dependent care eligible spending account (Dependent Care FSA). The annual contribution limit is:



\$7,500 per Household



\$3,750 per Person
(if married and filing separately)

Although most people incur more than the limit per year, we recommend reviewing how much you spend on eligible dependent care expenses each year to determine your election amount.



Funds Available as You Contribute

Funds become available as they are deducted from your paycheck and contributed to the plan. Once payroll is processed, your Dependent Care FSA contributions will be added to your account and available for reimbursement.



What Can I Use the Funds For?

This includes, but is not limited to, eligible:

- Childcare Center, Babysitter, Nanny (birth through age 12)
- Summer Day Camp
- Before- or After- School Care
- Disabled Dependent and/or Spouse Care
- Elder Care



FAST FACT

An easy way to 'set it and forget it' is by using our **Recurring Dependent Care Form**, which lets you submit one claim for the entire plan year and receive reimbursements after each payroll.

Changing Your Dependent Care FSA Election

To change your election after Open Enrollment, you must experience a qualifying life event. If this occurs, contact your employer to update your election. These events include:

- Change in marital status
- Change in the number of dependents
- Child turning age 13
- Increase due to birth, adoption, or marriage
- Decrease due to death, divorce, or loss of eligibility
- Gain or loss of eligibility due to a change in participant, spouse, or dependent
- Change in daycare providers
- Increase or decrease in the cost of qualifying daycare expenses
- Judgement, decree, or order requiring a change in coverage

COBRA



What is COBRA?

COBRA (shorthand for consolidated Omnibus Budget Reconciliation Act of 1985) is a federal law that requires employees of 20 or more employees who offer health care benefits to offer the option of continuing this coverage to individuals who would otherwise lose their benefits due to termination of employment, reduction in hours or certain other events. Individual states may also have COBRA-like laws that apply.

Which Benefits are Covered?

The following types of plans generally need to be offered to employees when COBRA is triggered (but only if they are offered to employees):

- Health care plans
- Medical spending accounts
- Dental plans

Which Events Trigger COBRA?

Events that trigger coverage are known as qualifying events. The following are qualifying events:

- An employee's voluntary or involuntary termination of employment, unless it is for gross misconduct
- An employee's reduction in hours of employment (e.g., full time or part time)
- A covered spouse's divorce or legal separation from an employee
- An employee's death
- An employee's entitlement to Medicare
- A covered dependent's change in status (for example, reaching an age that no longer qualifies the dependent for coverage under the parent's health plan)
- Active military duty when you don't voluntarily maintain health coverage
- Failure to return to work at the end of family and medical leave where coverage was in effect
- Your business bankruptcy

How long does COBRA coverage last?

Depending upon the type of event and who the beneficiary is, coverage could continue for 18 or 36 months after the date of the event of the coverage loss.:

- In the case of termination of employment or reduction in hours – 18 months for the employee and any covered dependents
- In the case of qualifying events for reasons other than termination of employment or reduction in Hours – 36 months of coverage

Employee Assistance Program



Who Is Eligible and When

- All employees at date of hire

Benefits You Receive

When you are dealing with personal situations, it can be difficult to be your best at work or at home. That's why Columbia Heights offers the Employee Assistance Program (EAP) administered by TELUS Health. The EAP gives you a place to turn for support any time of the day, or night, and 365 days a year. Support is available for whatever issues employees might be facing, including depression, marriage and relationships, legal issues, child/elder care challenges, parenting issues, financial concerns, grief management or substance abuse.

You can contact our FREE Employee Assistance Program toll-free at 866-451-5465 or you can visit the website at www.niseap.com.



Embedded Employee Assistance Program (EAP) with Claimant Assist

Support for Employees* with Life or Disability Insurance Through National Insurance Services



The EAP Program

Everyday life can be stressful and can affect your health, well-being, and performance. Fortunately, our Employee Assistance Program can aid in finding solutions. When facing personal problems, you might struggle with where to turn for help. The first step is usually the hardest, and guidance is often the key. That's why National Insurance Services (NIS) offers an Employee Assistance Program (EAP). An EAP offers a confidential place to find the answers that work for you.

Your EAP Service Provider

TELUS Health is a leader in the field of Employee Assistance and has been providing employee assistance services for over 40 years. TELUS Health has the experience to provide the broad range of services and guidance that is paramount to an EAP – whether it's help with day-to-day concerns or guidance through a challenging crisis. The information you discuss through the EAP is kept confidential in accordance with federal and state laws.

The EAP Process

When you access the EAP, TELUS Health counselors listen and take

action toward finding solutions. The next step may include meeting with a mental health counselor for up to three face-to-face visits, negotiating health insurance benefits, or referrals to community resources for legal and financial services.

Referrals and Resources

You can receive information and a listing of childcare and eldercare resources with confirmed vacancies meeting your specifications. If face-to-face mental health counseling sessions are required, TELUS Health counselors will refer you for counseling at a location that is convenient to your home or work. TELUS Health counselors can also refer you to self-help groups such as Alcoholics Anonymous or Gamblers Anonymous and community financial and legal resources for debt management.

Claimant Assist

NIS's Claimant Assist program offers special services to Long Term Disability claimants or Life Insurance beneficiaries at no charge. If you have Disability insurance coverage through NIS, our Long Term Disability Claimant Services are available to guide and counsel claimants and their immediate family

Under our EAP you can receive no-cost, confidential help for a wide variety of needs and concerns:

- Alcohol or Drug Addictions
- Anxiety
- Childcare
- Depression
- Eating Disorders
- Eldercare
- Family Conflict
- Financial or Legal Concerns
- Marital Difficulties
- Parenting Concerns
- Problem Gambling
- Relationship Problems
- Stress Management

EAP Services Are Available to You Two Ways:

Phone: 866.451.5465

Online: www.niseap.com
Login: NISEAP | **Password:** EAP
(Note: Password Is Case-Sensitive)

Claimant Assist Services Are Available:

866.472.2734

(over)

members. If you have Life insurance coverage through NIS, our Beneficiary Services Program provides counseling and assistance to beneficiaries when faced with the challenge of coping with loss.

Virtual Fitness

You have access to a virtual fitness platform through the EAP. LIFT session, one of the leading fitness providers, provides you with an easily accessible, effective and affordable way to reach your fitness goals anytime, anywhere for better health and well-being.

You can work out on your own with personalized programs and access coaches if you have questions, or choose to work under the live supervision of a coach online, in 1-1 personal or group sessions.

Access to Masters-Degreed Counselors 24-Hours a Day Through a Toll-Free Number

Up to three in-person assessment and counseling sessions.

- **Legal Assistance:** Counselors may refer you to a telephone and/or one in-person consultation with an attorney.
- **Financial Assistance:** Telephone consultation with a financial consultant to address questions on budgeting, taxes, and debt consolidation.
- **Eldercare Assistance:** Our specialists can help you locate eldercare options, such as residential care or in home care, provide support in dealing with the emotions of retirement, or legal aspects like estate planning. Use our website to find resources on retirement, from financial planning and calculators, to articles on coping with retirement stress, and filing your retirement days with meaningful activities.
- **Childcare Assistance:** Telephone consultation with a work-life professional to provide information, referrals, and resources related to childcare concerns.
- **Memorial Planning Assistance:** Telephone consultation with a work-life specialist to assist with memorial and funeral planning. Services include identifying potential locations, associated costs for services, and providing information to help coordinate logistics (Available to Life insurance beneficiaries only).

Your EAP and Claimant Assist Administrator:



134 North LaSalle Street, Suite 2200
Chicago, IL 60602

Telephone Assistance:

EAP: 866.451.5465

Claimant Assist: 866.472.2734

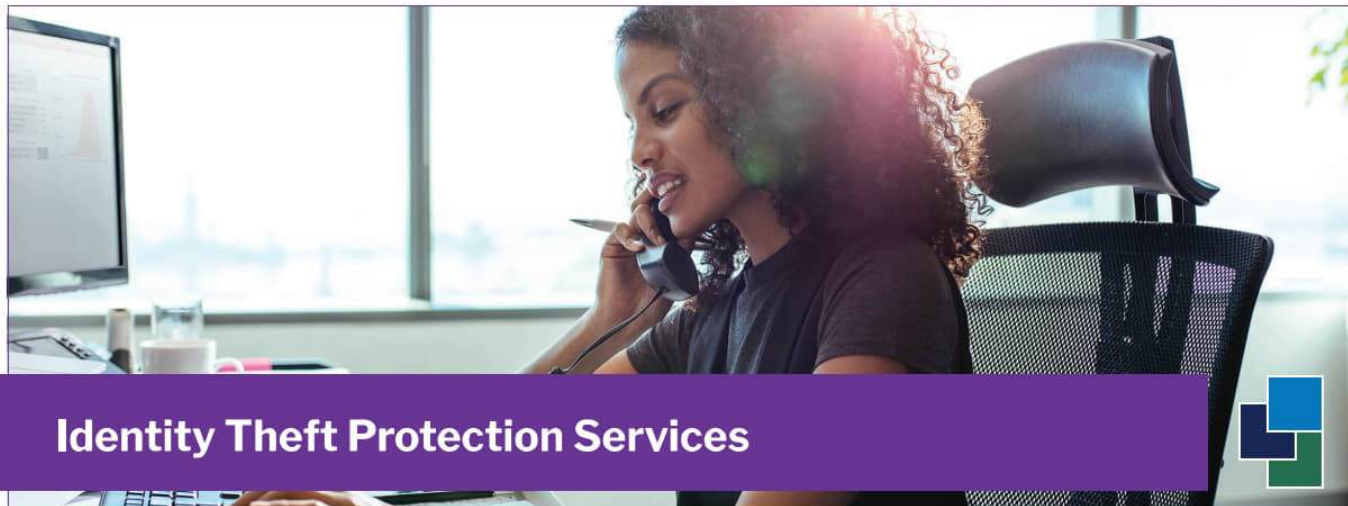
Online:

www.niseap.com | Login: NISEAP | Password: EAP
(Note: Password Is Case-Sensitive)

***The EAP is for use by the covered employee only. While issues may concern family members, all contacts to the EAP must be made by the employee.**

Identity Theft Program





Identity Theft Protection Services

In 2023, identity theft impacted at least 353 million individuals.¹ If you are a victim, the IDX Identity Theft Recovery specialists will provide concierge-style service every step of the way. Their expertise will save valuable time during this stressful process.

Your dedicated recovery specialist will work with you until the identity is restored to pre-fraud status. Support may include:

- Assistance with investigation of the suspected identity theft
- Guidance through the recovery process
- Recovery for all 9 types of identity theft
- Advice from trained professionals in identity protection
- Single point-of-contact if you are a victim
- Assistance with notifying law enforcement or local government agencies
- Limited Power of Attorney to work on the victim's behalf
- Documentation including fraud affidavit
- And much more



<https://app.idx.us/account-creation/NIS>

855.205.6010

PIN ID: NIS

"It was great knowing I had someone to help me resolve my identity theft issues and I didn't have to spend hours trying to figure out how to handle it on my own" - IDX member, Needham, MA

¹ <https://www.idtheftcenter.org/post/2023-annual-data-breach-report-reveals-record-number-of-compromises-72-percent-increase-over-previous-high/>

Resolution services offered to you by your employer and:



Corporate Headquarters: 300 North Corporate Drive, Suite 300
Brookfield, WI 53045

Offices Nationwide: 800.627.3660 | www.NISBenefits.com



PO Box 5008, Madison, WI 53705

Identity theft assistance services are provided by IDX, which is not affiliated with Madison National Life Insurance Company, Inc. Services provided by IDX are not part of Madison National Life's insurance products, and Madison National Life is not responsible for any acts or omissions of IDX in connection with or arising under identity theft assistance services. Access to IDX program is conditioned upon your employer remaining a Madison National Life customer and the program terms and conditions. This program does not provide credit repair services or any form of legal advice.

Group Legal





Everyone deserves legal protection.

At LegalShield, we've been offering legal plans to our members for over 40 years, creating a world where everyone can access legal protection—and everyone can afford it. Unexpected legal questions arise every day and with LegalShield on your side, you'll have access to a quality law firm 24/7, for covered personal situations. From real estate to speeding tickets to Will preparation, and beyond, we're here to help you with any personal legal matter—no matter how traumatic or how trivial it may seem. Because our dedicated law firms are prepaid, their sole focus is on serving you, rather than billing you.

Our Promise to You

As one of the first companies in North America to provide legal expense plans to consumers, we now provide legal services to over 1.4 million families across the U.S. and Canada—representing approximately 4 million people. And with over 650 employees dedicated to serving you, our promise remains the same: to provide outstanding legal services by quality law firms at an affordable price.

Why LegalShield

For as little as \$20 a month, LegalShield gives you the ability to talk to an attorney on any personal legal matter without worrying about high hourly costs. That's why, under the protection of LegalShield, you or your family can live your lives worry free.

Even better, you don't have to worry about figuring out which attorney to use—we'll do that for you. Our experienced attorneys focus specifically on our members and provide 24/7 access for covered emergencies.

Learn more about the LegalShield Legal Plan at
www.legalshield.com/info/legalplan

Marketed by: Pre-Paid Legal Services, Inc. dba LegalShield® and subsidiaries;
Pre-Paid Legal CasualtySM, Inc.; Pre-Paid Legal Access, Inc.; In FL: Pre-Paid Legal
Services, Inc. of Florida; In VA: Legal Service Plans of Virginia, Inc.; and PPL
Legal Care of Canada Corporation



LegalShield Legal Plan

Expected and unexpected legal issues arise every day. But with a LegalShield Legal Plan, a small monthly fee gets you access to advice and counsel on an unlimited number of personal legal issues from lawyers with an average of 19 years experience.

Advice & Consultation

Advice

Toll-free phone consultations with your Provider Law Firm for any personal legal matter, even on pre-existing conditions

Letters and Phone Calls on Your Behalf

Available at the discretion of your Provider Lawyer

Contract and Document Review

Contract/document review up to 15 pages each

24/7 Emergency Assistance

After-hours legal consultation for covered legal emergencies. Specific coverage depends on plan, such as: if you're arrested or detained, if you're seriously injured, if you're served with a warrant, or if the state tries to take your child(ren).

Family Matters (family plan only)

Uncontested Name Change Assistance*

One (1) uncontested name change prepared per member year by Provider Law Firm

Uncontested Adoption Representation*

Representation by your Provider Law Firm for uncontested adoption proceedings

Uncontested Separation/Divorce Representation*

Representation by your Provider Law Firm for uncontested legal separation, uncontested civil annulment and uncontested divorce proceedings

Representation

Trial Defense Services

Assistance if you or your spouse are named defendant or respondent in a covered civil action filed in court

Year	Pre-Trial Time	Trial Time	Total
1	2.5	57.5	60
2	3	117	120
3	3.5	176.5	180
4	4	236	240
5	4.5	295.5	300

For more information contact your Independent Associate:

Document Preparation

Standard Will Preparation

- Will preparation and annual reviews and updates for covered members
- Other documents available: Living Will, Health Care Power of Attorney

Residential Loan Document Assistance (family plan only)

Mortgage documents (as required of the borrower by the lending institution) prepared by your Provider Law Firm for the purchase of your primary residence

Auto

Motor Vehicle Services

- Non-criminal moving traffic violation assistance
- Motor vehicle-related criminal charge assistance
- Up to 2.5 hours of help with driver's license reinstatement and property damage collection assistance of \$5,000 or less per claim
- Available 15 days after enrollment
- Available only if member has a valid driver's license and is driving a non-commercial motor vehicle

IRS

IRS Audit Legal Services

- One hour of consultation, advice or assistance when you are notified of an audit by the IRS
- An additional 2.5 hours if a settlement is not achieved within 30 days
- If your case goes to court, you'll receive 46.5 hours of your Provider Law Firm's services
- Coverage for this service begins with the tax return due April 15 of the year you enroll

Additional Benefits

25% Preferred Member Discount

You may continue to use your Provider Law Firm for legal situations that extend beyond plan coverage. The additional services are 25% off the law firm's standard hourly rates. Your Provider Law Firm will let you know when the 25% discount applies, and go over these fees with you.

Your Plan Covers:

Family Plan:

- The member
- The member's spouse/domestic partner
- Never-married dependent children under age 26 living at home
- Dependent children under age 18 for whom the member is legal guardian
- Never married, dependent, children who are full-time college students up to age 26
- Physically or mentally disabled children living at home

Individual Plan:

An individual rate is available for those enrollees who are not married, do not have a domestic partner and do not have minor children or dependents. No family benefits are available to individual plan members. Ask your Independent Associate for details.

*These services are available 90 consecutive days from the effective date of your membership. For detailed information about the legal services provided for personal matters by the LegalShield contract, go to <http://www.legalshield.com/info/legalplan>. Business issues are not included; however, plans providing those services are available.



Access
LegalShield
on the go!

Activate your account on mylegalshield.com and then download our new smartphone app MyLegalShield. With this app, our members have access to their Provider Law Firm at the touch of a button.

Download the
free app from
the App Store
or Google Play.





Millions of people lose their identities every year.



Don't be one of them.

Identity theft has been the top consumer complaint filed with the FTC for 15 years straight. Victims are spending an exorbitant amount of time and money dealing with it. The criminals are getting smarter. And they're not going away. That's why you need a company that's more than a website. You need an established institution that understands all the potential threats, how to prevent them and how to restore any damage done.

**“My investigator gave me great advice
and the next day cleared up my situation.”**

- IDShield member - L.N. in Sioux City, NE



MONITOR MORE OF WHAT MATTERS

We monitor your identity from every angle, not just your Social Security number, credit cards and bank accounts. If any change in your status occurs, you receive an email update immediately.



COUNSEL WHEN YOU NEED IT

Our identity specialists are focused on protecting you. They are available to provide you with a complete picture of identity theft, walk you through all the steps you can take to protect yourself and answer any questions. Plus, they are available 24 hours a day, every day, in the event of an identity theft emergency. We're always here to help, no matter what.



RESTORE YOUR IDENTITY COMPLETELY

IDShield is the only company with an exclusive partnership with Kroll, the worldwide leader in theft investigative services. If a compromise occurs, contact your Licensed Private Investigator who will immediately begin restoring your identity to exactly the way it was.

IDSHIELD FAMILY
(for you, your spouse/domestic
partner and up to 8 minors)

IDSHIELD INDIVIDUAL
(for you)

IDShield

Identity Consultation Services

Members have unlimited access to identity consultation services provided by Kroll's Licensed Private Investigators. The Investigator will advise members on best practices for identity management tailored to the member's specific situation. Consultative services include:

Privacy and Security Best Practice

- Consult on best practices for the use and protection of a consumer's Social Security number and Personal Identifying Information (PII)
- Provide consultation on current trends, scams and schemes related to identity theft and fraud issues
- Discuss best practices for financial transactions, online activities and consumer privacy
- Provide the knowledge to best protect the member from identity theft and to be aware of their rights under federal and state laws
- Help members interpret and analyze their credit report and take steps to reduce pre-approved credit offers
- Consult with members regarding a public record inquiry, background search or credit freeze

Event-Driven Consultation Support

- Lost/stolen wallet assistance
- Data Exposure/Data Breach
- Safeguards

Alerts and Notifications

- Monthly identity theft updates to help educate and protect
- Data breach notifications

Consultation Services are limited to the solutions, best practices, legislation, and established industry and organizational procedures in place in the United States and Canada as determined beneficial or productive by a Kroll Licensed Private Investigator.

Privacy Monitoring

Black Market Website Surveillance (Internet Monitoring)

Monitors global black market websites, IRC (internet relay chat) channels, chat

rooms, peer-to-peer sharing networks, and social feeds for a member's Personally Identifiable Information (PII), looking for matches of name, date of birth, Social Security number, email addresses (up to 10), phone numbers (up to 10), driver's license number, passport number and/or medical ID numbers (up to 10).

Address Change Verification

Keeps track of a personal mailing address and alerts when a change of address has been requested through the United States Postal Service.

Security Monitoring

Black Market Website Surveillance (Internet Monitoring)

Monitors global black market websites, IRC (internet relay chat) channels, chat rooms, peer-to-peer sharing networks, and social feeds for a member's Personally Identifiable Information (PII), looking for matches of Social Security number, credit card numbers (up to 10) and bank account numbers (up to 10).

Court Records Monitoring

Detects criminal activity that may be associated with an individual's personal information, alerting them to signs of potential criminal identity theft. Credit Monitoring members have access to continuous credit monitoring through TransUnion. The credit monitoring service will alert members to activity up to and including new delinquent accounts, fraud alerts, improved account, new account, new address, new bankruptcy, new employment, new account inquiry, and new public records.

Credit Inquiry Alerts

Members will be notified via email when a creditor requests their TransUnion credit file for the purposes of opening a new credit account. Included are accounts that result in a new financial obligation, such as a new cell phone

account, a lease for a new apartment, or even for an application for a new mortgage.

Quarterly Credit Score Tracker

A quarterly credit score from TransUnion that plots the member's score quarter by quarter on a graph.

Payday Loan Monitoring

Alerts the subscriber when their personal information is associated with short-term, payday, or similar cash-advance loans.

Minor Identity Protection (Family Plan only)

Allows parents/guardians of up to 8 minors under the age of 18 to monitor for potential fraudulent activity associated with their child's SSN. Unauthorized names, aliases and addresses that become associated with a minor's name and date of birth may be detected.

Identity Restoration

Kroll's Licensed Private Investigators

perform the bulk of the restoration work required to restore a member's identity to pre-theft status.

IDShield Service Guarantee

We don't give up until your identity is restored.

We're confident in our ability to help protect your identity, but no one can prevent all identity theft. If you become a victim of identity theft while an IDShield member, we'll spend up to \$5 million using Kroll's industry-leading Licensed Private Investigators to do whatever it takes for as long as it takes to help recover and restore your identity to its pre-theft status.

Purchase of IDShield requires member to have a valid email address.

The following are excluded from the Services: Legal Remedy—Any Stolen Identity Event where the member is unwilling or unable to prosecute or otherwise bring a civil or criminal claim against any person culpable or reasonably believed to be culpable for the fraud or its consequences. Dishonest Acts—Any dishonest, criminal, malicious or fraudulent acts, if the member(s) that suffered the fraud personally participated in, directed or had knowledge of such acts. Financial Loss—Any direct or indirect financial losses attributable to the Stolen Identity Event, including but not limited to, money stolen from a wallet, unauthorized purchases of retail goods or services online, by phone, mail or directly. Pre-existing Stolen Identity Event Limitations -If the victim either had knowledge of, or reasonably should have had knowledge of, the misuse of his/her identity, credit, or other personal information based on information provided, or reasonably available, to the individual prior to enrollment in the program (each a "Prior Misuse"), such Prior Misuse or the consequences caused by it are not covered by the restoration services. However, individuals who have merely experienced the loss or unauthorized exposure of personal identifiers, including credit or debit card data, such as a data breach event, with no indication of actual misuse or identity theft resulting from that event, are not subject to the Prior Misuse exclusion hereunder. Business—The theft or unauthorized or illegal use of any business name, DBA or any other method of identifying business (as distinguished from personal) activity. Third Parties Not Subject to U.S. or Canadian Law—Restoration services do not remediate issues with third parties not subject to United States or Canadian law that have been impacted by an individual's Stolen Identity Event, such as financial institutions, government agencies, and other entities.

Marketed by: Pre-Paid Legal Services, Inc. dba LegalShield® and subsidiaries; Pre-Paid Legal CasualtySM, Inc.; Pre-Paid Legal Access, Inc.; In FL: Pre-Paid Legal Services, Inc. of Florida; In VA: Legal Service Plans of Virginia, Inc.; and PPL Legal Care of Canada Corporation

Voluntary Benefits



403(b), Roth 403(b) & 457 Deferred Compensation

To enroll in a 403(b) or Roth 403(b), contact one of the below vendors to set up an account. Once an account has been created, send in the Salary Reduction Agreement form located on the CHPS Benefits page.

Please review your Employment Agreement or Contract for participation & district match eligibility. Never provide personal information via email; use caution when providing it via voicemail.

VOYA – 403(b) and ROTH 403(b)

Capital Street Financial Services

Office: (651) 665-4300

Daniel Rickett

Toll Free: (800) 728-0144

85 East 7th Place, Suite 275

Fax: 651-665-0121

St. Paul, MN 55101

Email: drickett@capitalstreet.biz

VALIC – 403(b) and ROTH 403(b)

VALIC Financial Advisors, Inc.

Office: (952) 838-7800

Steve Bentley, Financial Advisor

Mobile: (612) 322-3839

7650 Edinborough Way, Suite 320

Toll Free: (800) 728-0144

Edina, MN 55435

Fax: (612) 601-8941

Email: steve.bentley@aig.com

EDUCATORS FINANCIAL SERVICES, Inc. – 403(b)

Joseph Batkiewicz

David Wolfe, Financial Advisor

41 Sherburne Ave

11599 Robinson Drive NW

St. Paul, MN 55103

Coon Rapids, MN 55433

Office: (651) 767-1284

Office: (763) 789-4010

Fax: (651) 292-4815

Fax: (763) 706-3955

Email: joebat@efsadvisors.com

Email: davidw@efsadvisors.com

403(b) Universal Availability Notice

The Employer (the “District”) offers a 403(b) plan for eligible employees of the District. Employees are eligible to participate as described below:

- ☒ All employees are eligible to participate in the 403(b) plan
- ☐ All employees are eligible to participate in the 403(b) plan except those who normally work fewer than ____ hours per week (must be 20 or less and generally equivalent to 1,000 hours or less in a normal work year)
- ☐ Other (describe) _____

A 403(b) plan is a tax-deferred retirement program that permits an employee to reduce his or her compensation on a pre-tax basis (a “deferral”) and have the deferral deposited into a 403(b) account that the employee sets up with a 403(b) vendor. Amounts deferred into a 403(b) account, and any earnings on those deferrals, are generally not taxed until the employee makes a withdrawal from his or her 403(b) account following separation from service with the District.

The District maintains a list of approved 403(b) vendors and appropriate contact information for each vendor. A copy of this list is available from appendix 1 and 2 of the plan adoption agreements. Employees should contact each vendor for information about the 403(b) products and services it offers.

To enroll in the 403(b) plan, an employee must complete necessary paperwork, such as a salary reduction agreement (“SRA”). The SRA will only apply to amounts earned after enrolling in the plan. This contribution will continue unless it is modified or revoked in the future. The District has established policies that enable you to increase or decrease your contribution, stop your contribution or change from one authorized 403(b) vendor to another. Employees may get the necessary enrollment forms from the payroll department. Additional information on District policies and other 403(b) plan rules can be obtained with the enrollment materials.

Disclosure to employees: The District has no liability for any employee’s election to participate in the 403(b) plan, choice of 403(b) vendor(s), or expected tax consequences resulting from participating in the 403(b) plan. The District does not provide tax, legal or investment advice and recommends that employees seek advice from professionals who specialize in these areas.

Special Enrollment Notice

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

Loss of Other Coverage

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

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

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

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

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

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name Heather Lynch

Address 1400 49th Ave NE

City Columbia Heights **State** MN

Telephone (763) 528-4584

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

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

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

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

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

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

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

Retiree health coverage:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both); or
- If retiree: Commencement of a proceeding in bankruptcy with respect to the employer.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Heather Lynch

The plan procedures for this notice, including a description of any required information or documentation, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period ¹ to sign up for Medicare Part A or B, beginning on the earlier of

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

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Name of the Plan: Blue Cross Blue Shield
Contact Name (*or Position*): Heather Lynch
Contact Email Address: lynchh@colheights.k12.mn.us
Contact Phone Number: (763) 528-4584

NOTICE OF PRIVACY PRACTICE

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your rights

You have the right to:

- ✦ Get a copy of your health and claims records
- ✦ Correct your health and claims records
- ✦ Request confidential communication
- ✦ Ask us to limit the information we share
- ✦ Get a list of those with whom we've shared your information
- ✦ Get a copy of this privacy notice
- ✦ Choose someone to act for you
- ✦ File a complaint if you believe your privacy rights have been violated

Your choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Share information in a disaster relief situation
- Contact you for fundraising efforts
- Market our services and sell your information

Our uses and disclosures

We may use and share your information as we:

- ✦ Help manage the health care treatment you receive
- ✦ Run our organization
- ✦ Pay for your health services
- ✦ Administer your health plan
- ✦ Help with public health and safety issues
- ✦ Do research
- ✦ Comply with the law
- ✦ Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- ✦ Address workers' compensation, law enforcement, and other government requests
- ✦ Respond to lawsuits and legal actions

Your rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- ✦ You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- ✦ We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- ✦ You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- ✦ We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- ✦ You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- ✦ We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- ✦ You can ask us not to use or share certain health information for treatment, payment, or our operations.
- ✦ We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- ✦ You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- ✦ We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- ✦ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- ✦ We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- ✦ You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- ✦ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by

sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

- ✦ We will not retaliate against you for filing a complaint.

Your choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payments for your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- ✦ Marketing purposes
- ✦ Sale of your information

Our uses and disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- ✦ We can use and disclose your information to run our organization and contact you when necessary.
- ✦ We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- ✦ Preventing disease
- ✦ Helping with product recalls
- ✦ Reporting adverse reactions to medications
- ✦ Reporting suspected abuse, neglect, or domestic violence
- ✦ Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- ✦ We can share health information about you with organ procurement organizations.
- ✦ We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- ✦ For workers' compensation claims
- ✦ For law enforcement purposes or with a law enforcement official
- ✦ With health oversight agencies for activities authorized by law
- ✦ For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

- ✦ We are required by law to maintain the privacy and security of your protected health information.
- ✦ We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- ✦ We must follow the duties and privacy practices described in this notice and give you a copy of it.
- ✦ We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General information

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. The open enrollment period each year for health insurance coverage through the Marketplace runs from Nov. 1 through Jan. 15. After the open enrollment period ends, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I save money on my health insurance premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year (adjusted to 8.39% for 2024 and 9.02% for 2025), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit¹.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Heather Lynch.

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 or health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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: Columbia Heights ISD 13
- 4. Employer Identification Number (EIN): 41-6000080
- 5. Employer phone number: (763) 528-4584
- 6. Employer address: 1400 49th Ave NE
- 7. City: Columbia Heights 8. State: MN 9. ZIP code: 55421
- 10. Who can we contact about employee health coverage at this job?: Heather Lynch
- 11. Phone number (if different from above): (763) 528-4584
- 12. Email address: lynchh@colheights.k12.mn.us

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

As your employer, we offer a health plan to:

- ☒ All employees. Eligible employees are: per employment contract.
- ☒ Some employees. Eligible employees are: those who work at least 30 hours per week.

With respect to dependents:

- ☒ We do offer coverage. Eligible dependents are: legal spouse, dependent children up to the age of 26, physically or mentally disabled children (must meet plan criteria) beyond age 26.
- ☐ We do not offer coverage.
- ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please review your benefit summaries for more information on applicable deductible(s) and coinsurance.

If you would like more information on WHCRA benefits, call your plan administrator at (763) 528-4584

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (763) 528-4584 for more information.

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 March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: 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://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)



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