Minneapolis Public Schools Employee Benefits Guide

2026

MINNEAPOLIS
PUBLIC SCHOOLS

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WELCOME

Welcome to the Minneapolis School District employee benefits program. It is our pleasure to provide you with a copy of the 2026 Employee Benefits Guide. Its purpose is to acquaint you with the benefits and health care plans offered by the Minneapolis Public School District. We believe this guidebook will assist you in understanding and selecting the benefits most helpful in meeting your individual needs.

You probably know that the District offers an extremely competitive and comprehensive benefits program for benefit eligible employees. It does so to provide employees with additional support as they work towards helping the District achieve its mission and strategic priorities. District employee benefits include medical, dental, vision, life, and long-term disability insurance coverage, along with two retirement plans (one defined benefit and one voluntary defined contribution plan), reimbursement accounts and health savings account options, wellness, and an employee assistance program. Additionally, the District has provisions for paid leave time (vacation and sick), family and medical leave, holidays, and other types of paid and unpaid leave.

We encourage you to keep this guidebook along with your other benefits information, as you may want to refer to it periodically. This guidebook is also available on the Benefits Department website at **drive.google.com/file/d/1X6VeHhU_JK6toNBNtywzvnq_gIlroOZR/view**.

You should know, however, that coverage or participation in most benefits outlined in this guidebook are not automatic. It is extremely important that you familiarize yourself with the various options and enroll in those that best fit your needs. Many of the plans are effective for the entire calendar year. If you are a union employee, you may have certain benefits that are part of your collective bargaining agreement. Please refer to your labor agreement for guidance (available on the Human Resources Department website at **www.mpschools.org/departments/human-resources/employee-relations-collective-bargaining)**.

As your need for certain employee benefits change, you will have opportunities to change your benefits choices - once per year through annual enrollment in the fall or immediately at the time you experience a qualified work/life event (i.e., marriage, birth/adoption of a child). Depending upon the event, you also may add or drop some benefits. Please refer to the Eligibility and Enrollment section of this guidebook for more information.

If you should have any questions, the Benefits Department is here to assist you:

Email: **Benefits@mpls.k12.mn.us**
Phone: (612) 668-0560
Fax: (612) 668-0535
Mail: 1250 West Broadway Avenue North, Minneapolis MN 55411

MINNEAPOLIS PUBLIC SCHOOLS
Urban Education. Global Citizens.

YOUR BENEFIT CHOICES

Minneapolis Public Schools strives to provide a wide variety of benefits for our employees. Some benefits are provided automatically at no cost while others are available if you choose them. Check the guide below to see which benefits you need to make a successful program designed just for you.

Keep this booklet and all coverage materials easily accessible, so that you may refer to them if necessary.

BENEFIT	CARRIER	WHO PAYS THE COST	EFFECTIVE DATE
Health Insurance	UnitedHealthcare	MPS & Employee	Date which plan is enrolled in online
Dental Insurance	Delta Dental	MPS & Employee	1st of the month following date which plan is enrolled in online
Vision Insurance	VSP Vision Care	Employee	1st of the month following date which plan is enrolled in online
Employee Assistance Programs (EAP)	AllOne Health	MPS	Date employee becomes a permanent benefit eligible employee
Group Term Life and AD&D Insurance	Sun Life	MPS	Date of hire
Long-term Disability Insurance	Sun Life	MPS	Date of hire
Supplemental Term Life Insurance	Sun Life	Employee	Date coverage is approved by carrier
Long-term Care	Newman Long-term Care	Employee	Date employee contacts Newman directly
Flexible Spending Accounts (FSA)	UnitedHealthcare	Employee	Date which plan is enrolled in online
Health Savings Account (HSA)	Optum Bank	Employee	Date which plan is enrolled in online
403(b) & 457 Savings Plans	Corebridge Financial	MPS & Employee	Date which plan is enrolled in online
457 Savings Plan	MSRS	MPS & Employee	Date which plan is enrolled in online
Defined Benefit Pension Plans	PERA	MPS & Employee	Date of hire
	TRA	MPS & Employee	Date of hire
Compensated Time Off and Holidays	MPS	MPS	Refer to CBA
Legal Assistance	LegalShield	Employee	Refer to CBA
Vitality – Wellness Program	Vitality	MPS	Date employee becomes a permanent benefit eligible employee
WellBeats – On Demand Fitness	Wellbeats	MPS	Date employee becomes a permanent benefit eligible employee

ELIGIBILITY

Employee Eligibility

For the purpose of benefits eligibility, employees are eligible to receive benefits as long as they are a permanent employee working at least 20 hours per week or have an FTE of 0.5 or more.

Employees covered by a union contract are entitled only to those benefits described in that labor agreement. Please refer to your union contract for details regarding your employee benefits.

All employees are eligible to participate in the Deferred Compensation Program, however only permanent benefit eligible employees will receive the District match. Please refer to the Retirement Summary Plan Description for details.

Temporary employees are ineligible for District-sponsored benefits.

Dependent Eligibility

If you are an eligible participant, you may also cover your eligible dependents under the health, dental, vision, and supplemental life and AD&D plans. Employees will be required to verify eligibility by providing appropriate documentation to the Benefits Department at time of enrollment. Enrolling ineligible dependents into the District's benefits program is a violation of District policy and will be treated accordingly. Eligible dependents include your:

- Legally Married Spouse (see below for more information);
- Domestic Partner (see below for more information);
- Dependent Children to the age of 26 including;
  - an Enrollee's natural or legally adopted child;
  - a child for whom the Enrollee or the Enrollee's spouse is the legal guardian;
  - a child covered under a valid qualified medical support order (as the term is defined under Section 609 of the Employer Retirement Income Security Act (ERISA) and its implementing regulations) which is enforceable against an Enrollee;
  - a stepchild of the Enrollee (that is, the child of the Enrollee's spouse)
  - a grandchild of the Enrollee or an Enrollee's spouse who is a newborn and resides with and is financially dependent on the covered grandparent. The grandchild must be either under 26 years of age or a disabled dependent;
  - an Enrollee's dependent who is (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and (b) chiefly dependent on the Enrollee for support and maintenance.

Legally Married Spouse Coverage: A copy of your marriage license AND one form of dated (within six months) documentation establishing current marital status such as a joint household bill, joint bank/credit account, or jointly filed federal tax return.

Domestic Partner Coverage (Eligible only if stated in union contract): A copy of a notarized affidavit of domestic partnership AND two forms of dated (within six months) documentation establishing current partnership status such as: a joint household bill, joint bank/credit account, joint mortgage or lease, front page of both federal tax returns showing current common address (with blacked out financial information), assignment of durable power of attorney, or designation as a beneficiary of life insurance or retirement plan.

ENROLLMENT

Enrollment & Changes

New hires and newly benefit eligible employees must enroll within thirty (30) days of their employment start date. Employees who elect to ensure their spouse, domestic partner (eligible only if stated in union contract) and/or dependents will be required to provide proof of eligibility. Benefits Department staff will verify eligibility status and assist with the process.

Medical coverage will be effective on the date in which the employee enrolls online. Dental and Vision coverage will be effective the first day of the following month from the date the employee enrolls online.

For those employees who start in the month of August, their medical, dental and/or vision insurance coverage will begin on September 1st, if enrollment is completed by August 31st. If enrolling on September 1st or later, medical coverage begins the day the employee enrolls online, and dental/vision insurance will begin the first day of the following month.

Payroll Deductions

Deductions for premiums are taken out of twelve (12) paychecks from January through June and then again out of eight (8) paychecks from September through December. Your deductions may differ slightly in the latter part of the year. Employees' deductions for January through June also include the premiums for July and August. The September through December deductions only include four (4) months of premiums.

In accordance with state and federal regulations, health benefit premiums paid towards domestic partner benefits will be deducted on a post-tax basis.

Employee Self Service

You can perform a variety of inquiries and make changes online, such as:

- View and update address and phone number
- View and update emergency contact information
- View pay statement
- View benefit elections
- Check your earnings history
- View and change your W-4 elections
- View and change your deferred compensation deductions

You can access the Neptune ESS system from the District website by going to **www.mpls.k12.mn.us** and click on Staff Login. You will want to login using your username and password. If you forgot your password, or are experiencing technical difficulties, please go to the MPS eHelpDesk website at **ehelpdesk.mpls.k12.mn.us/** or call (612) 668-0088.

ENROLLMENT

Notice of Special Enrollment Rights

If you are declining enrollment for yourself and/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 towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). ***This Special Enrollment opportunity is available only if you indicated (or otherwise as required) information regarding you or your dependents' other coverage on your initial enrollment form/waiver.***

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

*You do have up to 60 days to request enrollment after the loss of Medicaid coverage.

Qualifying Life Events

The elections that you make during your initial benefits eligibility period, or at the Annual Enrollment, will remain in effect for the next 12 months. During that time, if your life or family status changes you will be permitted to revise your benefits coverage to accommodate your new situation (according to the recognized events below). You are able to make benefits changes by contacting the Benefits Department by email at **Benefits@mpls.k12.mn.us** or call (612) 668-0560.

IRS regulations govern the circumstances through which you may make changes to your benefits, which benefits you can change, and which types of changes are permitted.

- All changes must be consistent with the qualified life event
- Changes must be accompanied by supportive documentation
- In most cases, you cannot change your benefit elections, but you may modify the level of coverage (In other words, you can add or delete dependents, enroll, or dis-enroll yourself or dependents, but not switch carriers or plans).
- Any changes in benefit levels must be completed within 30 days of the event

Recognized Qualifying Events:

- Marriage
- Death of spouse
- Divorce/legal separation/annulment
- Spouse gains or loses coverage from another eligible source
- Birth or adoption of child
- Death of dependent child
- Change in dependent eligibility

CHANGING YOUR BENEFITS

Annual Enrollment

Eligible employees who wish to change their benefits during annual enrollment are allowed a window of opportunity in the Fall of every calendar year. Benefit elections made during this period of annual enrollment are effective on January 1 of the following year.

Employees who wish to participate in health care or dependent care reimbursement account elections **must** enroll through NEPTUNE ESS online **every year**. In accordance with IRS regulations, those elections must be made every year regardless of whether they change or not.

Adding New Dependents

- Spouse or Stepchildren - you must submit the appropriate enrollment form within thirty (30) days of the date of the marriage to the Benefits Department. Coverage for your spouse and/or stepchildren will start on the first day of the month following the date of the marriage.
- Newborns and Children Placed for Adoption – you must submit the appropriate enrollment form within thirty (30) days after the date of birth for newborn child or thirty (30) days of the date of placement for your adopted child. Coverage starts on the date of birth or date of placement.
- Disabled Children or Disabled Dependents – you must submit the appropriate enrollment form within thirty (30) days of the date of eligibility. Coverage starts on the date of eligibility.
- If the enrollment form is received after the application period, your spouse and/or dependent must wait until the next annual enrollment to apply for coverage.

Special Enrollment Periods

Special enrollment periods are periods during which eligible employees and dependents may enroll under certain circumstances after the initial thirty (30) days when they were first eligible. The following conditions must be met:

1. Employee or dependent was covered under health insurance coverage at the time coverage was previously offered to the employee or dependent;
2. The employee must complete any required written waiver of coverage and state in writing that, at such time, other health insurance coverage was reason for declining enrollment;
3. The employee's or dependent's coverage is terminated because his/her continuation has been exhausted, they are no longer eligible for the Plan due to a divorce, legal separation, death, termination of employment, reduction in hours, or District's contributions toward coverage were terminated; and
4. The employee or dependent requested enrollment not later than thirty (30) days after the termination of coverage or District's contribution.

HEALTH INSURANCE

Insurance Carrier: UnitedHealthcare
Phone: (866) 633-2446
Website: myuhc.com/mps

Medical Plan Per Pay Check Costs

Teachers/ABE

Group	January to June		September to December	
	EE	Family	EE	Family
Plan 1	$30.00	$751.78	$30.00	$563.84
Plan 2	$0.00	$669.18	$0.00	$501.88
Plan 3	$0.00	$608.16	$0.00	$456.12

All Other Employees

Group	January to June			September to December		
	EE	EE + 1	Family	EE	EE + 1	Family
Plan 1	$131.39	$385.97	$561.70	$98.55	$289.47	$421.28
Plan 2	$60.62	$284.90	$431.90	$45.46	$213.68	$323.92
Plan 3	$0.00	$200.38	$324.03	$0.00	$150.29	$243.02

Medical Plan Per Month Costs*

Teachers/ABE

Group	Monthly Costs	
	EE	Family
Plan 1	$50.00	$1,127.67
Plan 2	$0.00	$1,003.76
Plan 3	$0.00	$912.24

All Other Employees

Group	Monthly Costs		
	EE	EE + 1	Family
Plan 1	$197.09	$578.95	$842.55
Plan 2	$90.93	$427.35	$647.85
Plan 3	$0.00	$300.57	$486.04

**Monthly medical plan costs are an average monthly cost over the full plan year.*

Notes:

1. *Benefit deductions are taken during the school year. Biweekly rates are subject to change if your start date is after January 1st.*

HEALTH INSURANCE

Plan 1	You Pay In-Network		You Pay Out-of-Network
	Tier 1	Non-Tier 1	
Calendar Year Deductible The in and out-of-network deductibles accumulate separately Does not include copay or coinsurance amounts	$1,000 Single $2,000 Family		$1,500 Single $3,000 Family
Calendar Year Out-of-Pocket Maximum (Combined Medical AND Pharmacy)	$3,500 Single $7,000 Family		$5,500 Single $11,000 Family
Lifetime Maximum	Unlimited		Not covered
Preventative Health Care (Routine physical, eye exam, well-childcare, prenatal, and postnatal care, immunizations)	You pay nothing		Not covered
Office Visits			
Primary care physician			
Well-being participant	$30 copay	$55 copay	50% after ded.
Non-well-being	$50 copay	$75 copay	
Specialist visit			
Well-being participant	$30 copay	$55 copay	50% after ded.
Non-well-being	$50 copay	$75 copay	
On-line care (Virtual Visits)	No charge	No charge	Not covered
Emergency Care	$30 copay (Well-being participant)		
Urgent care Clinic	$50 copay (Non-Well-being)		
Hospital Emergency Room	20% after deductible		
Ambulance	20% after deductible		
Tests			
Diagnostic tests (X Ray, blood work)	No charge	No charge	50% after ded.
Imaging (CT/PET scans, MRI)	20% after ded.	20% after ded.	50% after ded.
Inpatient Hospital Care	20% after ded.	20% after ded.	50% after ded.
Outpatient Hospital Care	20% after ded.	20% after ded.	50% after ded.
Prescription Drugs:			
Retail Copayment for 31-day supply			
Generic from formulary	$5 Copay	$5 Copay	$5 Copay
Brand from formulary	$40 Copay	$40 Copay	$40 Copay
Medications not on formulary	$60 Copay	$60 Copay	$60 Copay
Specialty	20% up to $200	20% up to $200	20% up to $200
Mail Order Copayment for 90-day supply			Not covered
Generic from formulary	$10 Copay	$10 Copay	
Brand from formulary	$80 Copay	$80 Copay	
Medications not on formulary	$120 Copay	$120 Copay	
Specialty	20% up to $200	20% up to $200	

HEALTH INSURANCE

Plan 2	You Pay In-Network		You Pay Out-of-Network
	Tier 1	Non-Tier 1	
Calendar Year Deductible The in and out-of-network deductibles accumulate separately Does not include copay or coinsurance amounts	$2,000 Single $4,000 Family		$3,000 Single $6,000 Family
Calendar Year Out-of-Pocket Maximum (Combined Medical AND Pharmacy)	$5,000 Single $10,000 Family		$6,750 Single Unlimited Family
Lifetime Maximum	Unlimited		$1,000,000
Preventative Health Care (Routine physical, eye exam, well-childcare, prenatal, and postnatal care, immunizations)	You pay nothing		Not covered
Office Visits			
Primary care physician			
Well-being participant	$35 copay	$60 copay	50% after ded.
Non-well-being	$55 copay	$80 copay	
Specialist visit			
Well-being participant	$35 copay	$60 copay	50% after ded.
Non-well-being	$55 copay	$80 copay	
On-line care (Virtual Visits)	No charge	No charge	Not covered
Emergency Care	$35 copay (Well-being participant)		
Urgent care Clinic	$55 copay (Non-Well-being)		
Hospital Emergency Room	20% after deductible		
Ambulance	20% after deductible		
Tests			
Diagnostic tests (X Ray, blood work)	No charge	No charge	50% after ded.
Imaging (CT/PET scans, MRI)	20% after ded.	20% after ded.	50% after ded.
Inpatient Hospital Care	20% after ded.	20% after ded.	50% after ded.
Outpatient Hospital Care	20% after ded.	20% after ded.	50% after ded.
Prescription Drugs:			
Retail Copayment for 31-day supply			
Generic from formulary	$5 Copay	$5 Copay	$5 Copay
Brand from formulary	$40 Copay	$40 Copay	$40 Copay
Medications not on formulary	$60 Copay	$60 Copay	$60 Copay
Specialty	20% up to $200	20% up to $200	20% up to $200
Mail Order Copayment for 90-day supply			Not covered
Generic from formulary	$10 Copay	$10 Copay	
Brand from formulary	$80 Copay	$80 Copay	
Medications not on formulary	$120 Copay	$120 Copay	
Specialty	20% up to $200	20% up to $200	

HEALTH INSURANCE

Plan 3	You Pay In-Network		You Pay Out-of-Network
Calendar Year Deductible The in and out-of-network deductibles accumulate separately Does not include copay or coinsurance amounts	Well-being participant $1,700 Single $3,400 Family	Non-Well-being $1,950 Single $3,900 Family	$2,600 Single $5,000 Family
Calendar Year Out-of-Pocket Maximum (Combined Medical AND Pharmacy)	$3,300 Single $6,600 Family		$5,000 Single $10,000 Family
Lifetime Maximum	Unlimited		$1,000,000
Preventative Health Care (Routine physical, eye exam, well-childcare, prenatal, and postnatal care, immunizations)	You pay nothing		Not covered
Office Visits			
Primary care physician	20% after ded.		40% after ded.
Specialist visit	20% after ded.		40% after ded.
On-line care (Virtual Visits)	No charge		Not covered
Emergency Care			
Urgent care Clinic	20% after ded.		
Hospital Emergency Room	20% after ded.		
Ambulance	20% after ded.		
Tests			
Diagnostic tests (X Ray, blood work)	20% after ded.		40% after ded.
Imaging (CT/PET scans, MRI)	20% after ded.		40% after ded.
Inpatient Hospital Care	20% after ded.		40% after ded.
Outpatient Hospital Care	20% after ded.		40% after ded.
Diagnostic tests (X Ray, blood work)	No charge		50% after ded.
Imaging (CT/PET scans, MRI)	20% after ded.		50% after ded.
Inpatient Hospital Care	20% after ded.		50% after ded.
Outpatient Hospital Care	20% after ded.		50% after ded.
Prescription Drugs:			
Retail Copayment for 31-day supply			40% after ded
Generic from formulary	20% after deductible		
Brand from formulary	20% after deductible		
Medications not on formulary	20% after deductible		
Specialty	20% up to $200		
Mail Order Copayment for 90-day supply			Not covered
Generic from formulary	20% after deductible		
Brand from formulary	20% after deductible		
Medications not on formulary	20% after deductible		
Specialty	20% up to $200		

Plan 3 has a non-embedded deductible. Before benefits will pay, an individual or any member of your family must meet the entire amount of the deductible. For example, if you, your spouse and two kids are enrolled in Plan 3 with a non-embedded deductible, either you or the combination of you and your family members need to meet the entire $3,400 family deductible for the wellbeing plan or $3,900 family deductible for the non-well-being planned deductible before the plan will pay benefits.* **Please note: *Based upon IRS guidance, MPS has determined that the clinic provides significant medical benefits (other than preventive care) for our staff at no charge. Employees enrolled in Plan 3 will not be allowed access to the MPS clinic.*

SELF-FUNDED MEDICAL

Medical coverage helps you and your family access routine and preventive health care at a reasonable cost and helps to protect you against the catastrophic costs of major illnesses or injuries.

The Minneapolis Public School Districts' medical program is self-funded. This means that the District takes on all risk for paying claims. UnitedHealthcare provides third-party administrative services, such as providing access to a network of providers and processing of claims.

The District does not price the plan to make a profit. Employees also pay a portion of the cost through deductibles and coinsurance. The District pays the remainder of the claims and administrative costs.

Make the Most of Your Health Benefits

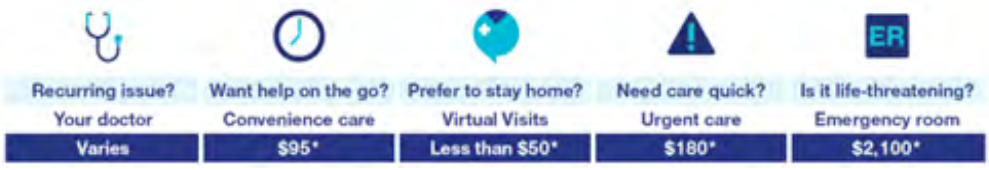
Navigating a new health plan can be confusing. Fortunately, there are things you can do to help your experience, make sure the transition goes as smoothly as possible and make the most of your health benefits in the process. Consider this checklist and click on the arrows below to get started:

1. **Contact your doctor**
   Before your coverage begins, tell your doctor that your medical insurance has changed and make sure they have the new card on file.
2. **Set up your online account**
   Register on myuhc.com to help you manage your health plan using our online portal, including tools and information to help you:

- Learn how your benefits work
- Estimate and compare costs
- See what is covered
- Access your health plan ID card
- View claims, copays, and deductibles
- Find network doctors and pharmacies
- Refill prescriptions
- And more

Go to myuhc.com and click on "Register ›" to get started and visit the App Store® or Google Play™ to download the UnitedHealthcare app.

3. **Talk to your doctor about your prescriptions**
   Contact your doctor to make sure they begin processing your prescription refills through your new health plan. Simple ways to save:
   - Visit myuhc.com to check your prescription coverage and find a network pharmacy
   - Talk to your doctor or pharmacist about lower-cost alternatives
   - Sign up for home delivery to get a 90-day prescription of regular medications for less
   - Enroll in our specialty pharmacy program to work with someone who specializes in your condition
4. **Know where to go for care**
   When you need care, how much you pay can depend on where you go. A great place to start is with your primary care doctor. But for serious or life-threatening conditions, you should call 911 or go to an emergency room



5. **Still not sure where to go?**
   Sign in to myuhc.com or call the member phone number on your ID card. For quality, cost-effective care, choose UnitedHealth Premium® program providers. These doctors are more likely to follow national guidelines developed by doctors for doctors.

BEHAVIORAL HEALTH

Reaching out may be hard — especially if you might not want anyone to know you are hurting. From the privacy of home and the convenience of your mobile device or computer, you can receive caring support from a licensed therapist.

Child and Family Behavioral Health Coaching

Sometimes, being a parent can feel joyful. Other times, it can feel like a constant struggle. Maybe getting your kids to talk feels impossible. Perhaps, you are worried about their behavior. Or maybe you know they need help, but you are not sure where to look. Child and Family Behavioral Health Coaching from Bend Health can help.

Available at no additional cost to families with children ages 1–17, it offers:

- **Support from an experienced coach** – Coaches are certified or have a master's degree, and they are supervised by licensed practitioners
- **Online coaching sessions** – Get up to four 45-minute confidential sessions per month at no additional cost to you
- **Unlimited messaging** – Talk with your coach between sessions with secure in-app messaging
- **More resources** – Look at educational content anytime, designed to help you better understand what you talk about with your coach
- **Referrals** – If your family needs more support, your coach can offer referrals to therapists and child adolescent psychiatrists

Coaches can help with what your family needs:

- Anger issues
- Anxiety
- Attention-deficit/hyperactivity disorder (ADHD)
- Bullying
- Depression
- Obsessive-compulsive disorder (OCD)
- Self-esteem
- Sleep issues
- Social media or technology addiction
- Stress
- Substance use
- Trauma
- Other concerns

Connect with a coach at **bendhealth.com/coaching**

Virtual therapy offers confidential counseling and includes:

Private video sessions
Get 1-on-1 support —in your home and at a time that is convenient for you.

Help with coping — for children, teens, and adults
Your licensed therapist may provide a diagnosis, treatment and medication if needed.

Similar standard of care as in-person visits
You can see the same therapist with each appointment and establish an ongoing relationship.

Virtual therapy is designed to help treat conditions like:

- ADD/ADHD
- Addiction
- Anxiety
- Depression
- Mental health disorders

Sign in or register on **myuhc.com**®. Then, go to Find Care & Costs Virtual Care Behavioral Health Care Get Started and call the provider to set up an appointment. Or call the telephone number on your health plan ID card.

SUPPORT

Maven Maternity Support

The Maven team is built of clinical leaders, engineers, designers, and operators who all collaborate to deliver localized support to members in 175 countries.

Maven partners UnitedHealthcare to deliver personalized care and intuitive benefit management to the district's members. As individuals continue to face barriers to care, including limited access to providers, rising costs, systemic inequities, and legal and regulatory limitations, we show up when our members need us most.

Members and their partners have free access to Maven for 24/7 pregnancy and postpartum support and guidance – all in one app. You can get support with things like:

- Creating your birth plan
- Breastfeeding or bottle-feeding support
- Navigating Infant Sleep
- Returning to work
- Managing your mental Health

Scan the QR code to get started or go to **mavenclinic.com/join/uhc-join** or download the Maven Clinic app.

AbleTo™

It is nice to know that support is available

If you are feeling stressed, overwhelmed, or exhausted, you are not alone. The AbleTo virtual behavioral coaching program is designed to help you learn ways to cope and start feeling better.

AbleTo virtual behavioral coaching is here to help

Gaining control of worries. Facing tough challenges head-on. Releasing tension. AbleTo is ready to help you move forward with a tailored-to-you 8-week coaching program, including:

- A dedicated mental health coach for 1-on-1 support that is focused on your needs and goals
- Digital activities for practice and progress between sessions
- Confidential, convenient weekly meetings with a coach via phone or video chat
- 24/7 unlimited access to resources and tools — like breathing exercises and meditations — on your smartphone, tablet, or computer

A way to feel less stress at no additional cost

AbleTo virtual behavioral coaching is included in your health plan at $0 cost-share.
Visit ableto.com/exploremore or scan the code with your smartphone.

Calm Health

The Calm Health app provides programs and tools to help support your mental health and well-being all at your own pace. The Calm app brings you a library of support including mindfulness content and programs created by psychologists for a variety of health experiences and life stages. This information is designed to help you:

- **Learn techniques to improve well-being** – Find tools, music and sounds to help you meditate, improve focus, move mindfully, and feel calm
- **Work toward goals** – Join self-guided self-care programs, and track your progress along the way
- **Support your mind and body** – Access mental health information and support to help you strengthen the mind-body connection

You'll first need to sign in to your account on **myuhc.com** or the UnitedHealthcare app. If you don't have an account, select ***Register*** to create one.

VIRTUAL VISIT BY UNITEDHEALTHCARE

Account Administrator: UnitedHealthcare
Website: www.myuhc.com/virtualvisits

Do you have the flu? Or a child with pinkeye?

Now there is a way to get care quickly and conveniently for these and over 40 other common conditions. It is called Virtual Visit, an online clinic that treats everyday illnesses so you – or your kids – can get better faster.

Online Diagnosis and Prescriptions

Developed by UnitedHealthcare, Virtual Visit is a great option for getting help with simple medical conditions like cold and flu, ear pain and sinus infections. You will take a quick online interview that checks your history and makes sure your problem is not serious.

Trusted Advice

With Virtual Visits, you are helped by nurse practitioners with experience in treating common conditions. They can also write prescriptions. If you have questions during or after your visit, they are always available

Fast Response

When you finish your interview, a nurse practitioner reviews it in about 20 minutes. Your personalized Treatment Plan notification will come to you by email or text. Then just log on to myuhc.com/virtualvisits to view it. It will include your diagnosis with suggestions to help you get better. If you need a prescription, Virtual Visit will send it to the pharmacy you choose.

How a Virtual Visit Works

Here's how Virtual Visits work and the steps you will need to take.

- Complete a brief medical history anytime at myuhc.com/virtualvisits.
- Request a visit when you are sick.
- Get a diagnosis and advice and guidance on treatment in 20 minutes or less.
- Pay $54 or less with your UnitedHealthcare plan.

Affordable Care

- **Members in Plan 1, Plan 2, or Plan 3**: Virtual Visits are free.

VIRTUAL VISIT BY UNITEDHEALTHCARE

Telehealth vs. Telemedicine Vendor/Virtual Visit

Telemedicine Vendor/Virtual Visits are general terms used to describe clinical services provided to patients via electronic communications **through a vendor**. These are covered by MPS' medical plans at 100%. Examples include Teladoc and Doctor on Demand.

Telehealth is a general term used to describe clinical services provided to patients through electronic communications not through a vendor. This can be patient-to-physician or physician-to-physician. **These are typically viewed as an office visit.** Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health care.

Examples:

- Patient is consulting with a specialist that is out of their geographical area
- Patient has a virtual visit with their PCP

Virtual Visit is simple to use and always there when you need it.
Learn more about Virtual Visits and find out what it can treat at myuhc.com/virtualvisits.

DENTAL INSURANCE

Insurance Carrier: Delta Dental of Minnesota
Phone Local: (651) 406-5916
Phone Toll Free: (800) 553-9536
Website: www.deltadentalmn.org
Networks: Delta Premier and Delta PPO

Dental Plan Per Pay Check Costs

Teachers/ABE

Group	January to June			September to December		
	EE	EE + 1	Family	EE	EE + 1	Family
Dental Plan	$5.56	$11.11	$16.67	$4.17	$8.33	$12.50

All Other Staff

Group	January to June			September to December		
	EE	EE + 1	Family	EE	EE + 1	Family
Dental Plan	$4.77	$10.45	$16.89	$3.57	$7.84	$12.67

Dental Plan Per Month Costs*

Teachers/ABE

Group	Monthly Costs		
	EE	EE + 1	Family
Dental Plan	$8.33	$16.67	$25.00

All Other Staff

Group	Monthly Costs		
	EE	EE + 1	Family
Dental Plan	$7.15	$15.67	$25.33

**Monthly dental plan costs are an average monthly cost over the full plan year.*

Notes:

1. *Benefit deductions are taken during the school year. Biweekly rates are subject to change if your start date is after January 1st.*

DENTAL INSURANCE

Am I able to go to any dentist?

You have the freedom to see any dentist. However, dentists who participate in the Delta Dental PPO or Delta Dental Premier Networks have agreed not to charge more than our maximum allowable amount. This can result in lower out-of-pocket costs. Choosing a dentist in the Delta Dental PPO network may save you even more money. As an added convenience, you never have to file a claim when you use a participating dentist – the dentist files the claim for you.

How do I find a participating dentist?

Finding a participating dentist is easy. Simply visit **www.deltadentalmn.org** and use the interactive Dentist Search tool, or call Customer Service toll-free at (800) 553-9536

If I don't sign up as a new hire, can I sign up in the future?

Yes. Employees will be able to elect coverage after their initial new hire enrollment period either during the annual enrollment period or through a qualifying status change.

Dental Summary of Benefits

After you have satisfied the dental deductible, if applicable, your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta is different for Delta Dental PPO dentists, participating dentists, and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase. If a Delta Dental PPO dentist provides dental services, the deductible will be waived, and the payment percentages may increase, and discounts may apply which will result in lower out-of-pocket costs to you.

Unlike medical conditions, which can be unpredictable and catastrophic, most dental problems are preventable. Preventive care, including regular checkups and cleanings, is the key to maintaining good oral health. Problems can be diagnosed early and treated without extensive testing or elaborate and expensive procedures. That keeps the costs of dental care much lower than those of medical care.

To avoid any misunderstanding of benefit payment amounts, ask your dentist about his or her participation status with Delta and Delta Dental PPO prior to receiving dental care. You may also request a pre-estimate of benefits before the work is performed.

DENTAL INSURANCE

Dental Benefit Description	Delta Dental PPO (In-Network)	Delta Dental Premier (In-Network)	Non-Participating (Out-of-Network)
Annual Deductible –Per Coverage Year The deductible does not apply to check-ups, teeth cleanings, or braces.	$25 per person	$50 per person	
Annual Maximum –Per Coverage Year All services are subject to the annual maximum benefit and will not be paid if your annual maximum benefit has been reached.	$1,300		
Lifetime Ortho Plan Maximum – **per eligible person**	$1,000		
Lifetime Ortho Plan Maximum – **per eligible person** **Diagnostic & Preventive Services** Exams and Cleanings (2 per year) X-rays and fluoride treatments	100%	80%	80% of allowable maximum fee
Basic Services Emergency treatment for relief of pain, sealants, space maintainers, amalgam restorations (silver filings) and composite resin restorations (white fillings)	80%	80%	80% of allowable maximum fee
Endodontics Pulpotomies on primary teeth for dependent children Root canal therapy on permanent teeth	80%	80%	80% of allowable maximum fee
Periodontics Surgical/nonsurgical periodontics	80%	80%	80% of allowable maximum fee
Oral Surgery Surgical/nonsurgical extractions, all other oral surgery	80%	80%	80% of allowable maximum fee
Major Restorative Services Crowns and composite resin restorations (white fillings) on posterior (back) teeth	50%	50%	50% of allowable maximum fee
Prosthetic Repairs and Adjustments Denture adjustments and repairs, bridge repairs	80%	80%	80% of allowable maximum fee
Prosthetic Repairs and Adjustments Denture adjustments and repairs, bridge repairs	$ 50%	50%	50% of allowable maximum fee
Orthodontics Treatment for the prevention/correction of malocclusion, available for dependent children only, age 8 to 19	50%	50%	50% of allowable maximum fee

VISION INSURANCE

Insurance Carrier: VSP Vision Care
Phone: (800) 877-7195
Website: www.VSP.com

Vision Plan Per Pay Check Costs

Standard Plan

Group	January to June		September to December	
	EE	Family	EE	Family
Vision Plan	$3.61	$9.81	$2.71	$7.35

Premier Plan

Group	January to June		September to December	
	EE	Family	EE	Family
Vision Plan	$5.00	$13.78	$3.75	$10.33

Vision Plan Per Month Costs*

Standard Plan

Group	Monthly Costs	
	EE	Family
Vision Plan	$5.42	$14.71

Premier Plan

Group	Monthly Costs	
	EE	Family
Vision Plan	$7.50	$20.66

Vision Plan Annual Costs

Standard Plan

Group	Annual Costs	
	EE	Family
Vision Plan	$65.02	$176.50

Premier Plan

Group	Annual Costs	
	EE	Family
Vision Plan	$89.95	$247.97

**Monthly vision plan costs are an average monthly cost over the full plan year.*

Notes:

1. *Benefit deductions are taken during the school year. Biweekly rates are subject to change if your start date is after January 1st.*

VISION INSURANCE

ID cards are not necessary under VSP's paperless benefit delivery model. By going paperless, we are supporting the environment while providing MPS employees with online solutions that have more up-to-date information than paper or plastic ID cards can provide. The card aids as a convenient reminder of your vision coverage, but it is not required to receive services.

To use VSP benefits under our paperless model, simply follow these three easy steps:

1. Contact a VSP preferred provider at www.vsp.com or call (800) 877-7195
2. State that you are covered by VSP
3. Provide the covered member's name and last four digits of the Social Security number

VSP VISION CARE		
Vision	**Standard Plan**	**Premier Plan**
Well Vision Exam **Focuses on your eye health and overall wellness**	$10 copay every calendar year	$10 copay every calendar year
Prescription Glasses **Lenses:** *Single vision, lined bifocal, lined trifocal lenses *Polycarbonate lenses for dependent children	$25 copay every calendar year	$25 copay every calendar year
CAN RECEIVE ALLOWANCE FOR FRAMES OR GLASSES		
Frames: Allowance for wide selection of frames	$150 every other calendar year and 20% off amount over allowance $80 Costco Allowance	$175 every calendar year and 20% off amount over allowance $95 Costco Allowance
Contacts (instead of glasses)	$150 every calendar year and 20% off amount over allowance Up to $60 copay for contact lens fitting	$175 every calendar year and 20% off amount over allowance Up to $60 copay for contact lens fitting

FLEXIBLE SPENDING ACCOUNTS (FSA)

Claims Administrator: UnitedHealthcare
Website: welcometouhc.com/fsa or myuhc.com
Plan Year: January 1st - December 31st

The Minneapolis Public Schools Health and Dependent Care Flexible Spending Accounts (FSAs) allow you to use tax-free dollars to reimburse yourself for a wide variety of health and/or dependent care expenses that are not covered through your other benefit plans. The annual amount you elect to contribute to each account will be divided into equal amounts and deducted from your paycheck pre-tax (before Federal and, in most cases, State and Local income taxes are withdrawn).

Rules and Regulations

Plan your annual FSA contribution amounts carefully; the election you make when you enroll is binding for the entire plan year (January 1 to December 31) unless you have a qualifying status change. Additionally, the IRS imposes some rules and restrictions on the way you can use FSAs, such as:

- You must incur eligible expenses during the plan year
- If you incur fewer expenses than expected, any money remaining in your Dependent Care FSA and any balance above $680 in your Health Care FSA at the end of the year will be forfeited; you can roll over up to $680 from one plan year to the next for the Health Care FSA only.
- You cannot transfer money from one account to another; money in your Health Care FSA cannot be used for dependent care expenses, and money in your Dependent Care FSA cannot be used for health care expenses.
- You can only make changes to your contribution amounts with a qualified status change and the change being made must be consistent with the qualified event; these include birth or adoption, marriage, divorce, death of a spouse or dependent, change from part-time to full-time or full-time to part-time employment, termination or commencement of spouse's employment, unpaid leave of absence, significant change in health coverage due to spouse's employment.

Dependent Care FSA

Maximum contribution is $7,500 per family* per plan year

Expenses for dependent care services for children under age 13, a disabled spouse, or incapacitated parent are eligible for reimbursement from your Dependent Care FSA as long as you incur them while you and your spouse work or attend school full-time.

**The maximum Dependent Care contribution is $7,500 per family, per year, as set by the IRS or $3,750.00 if you are married and filing a separate income tax return.*

Health Care FSA

Maximum contribution is $3,400 per plan year

This account reimburses you on a pre-tax basis for eligible out-of-pocket expenses including deductibles, copays, co-insurance, certain over the counter drugs and other such expenses not covered by your medical or dental plan.

All claims with dates of service during the 2026 plan year must be submitted to UnitedHealthcare by 1:00 pm CST on March 31st, 2027. Any claim(s) with a date of service for the 2026 plan year submitted after March 31st, 2027 will be denied.

FLEXIBLE SPENDING ACCOUNTS (FSA)

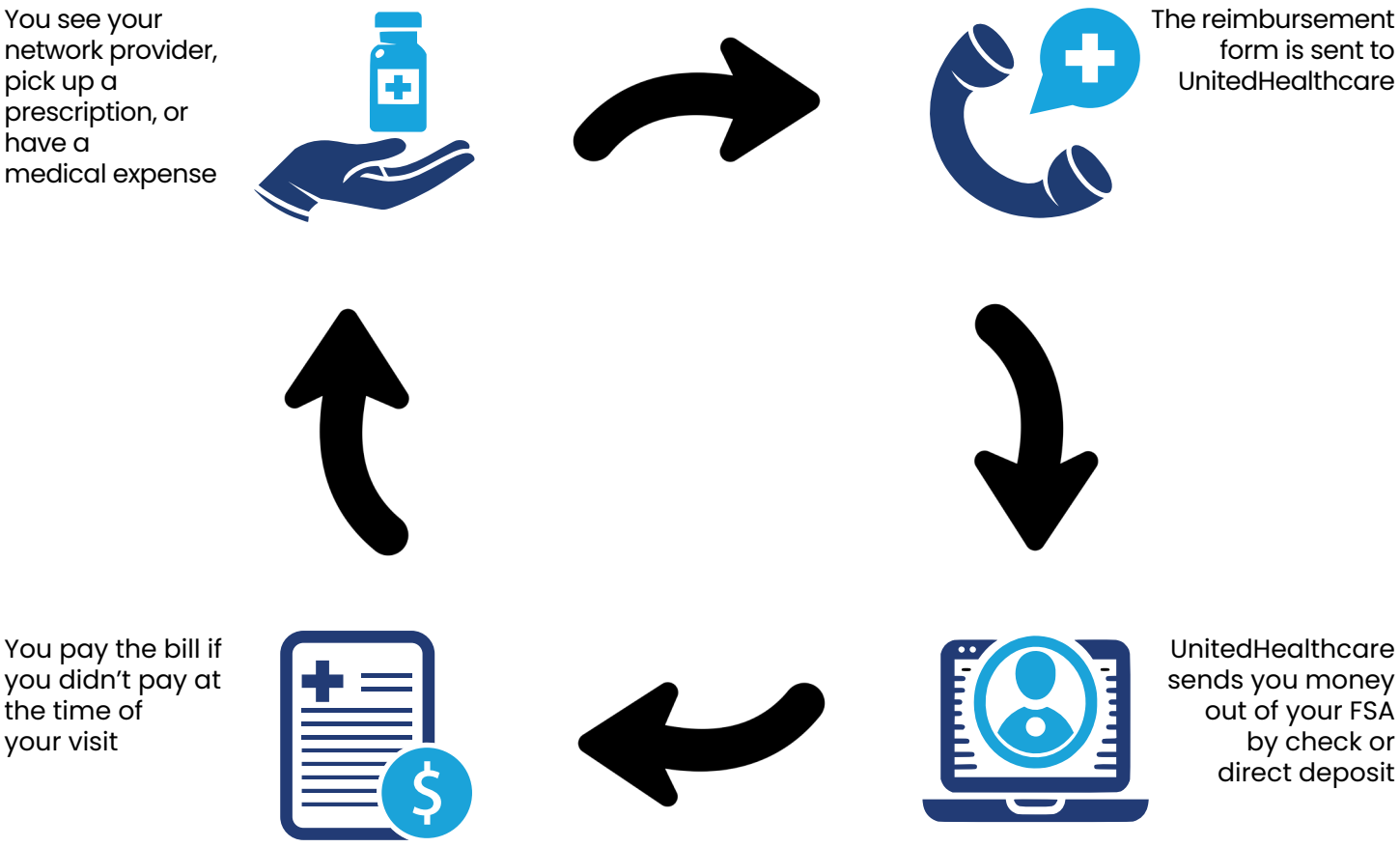
How do I get reimbursed for medical and/or dependent care expenses?

After you incur a health care or dependent care expense, you must file a claim along with verification of the expense. Once your claim has been received and processed, you will be reimbursed by check or direct deposit.

There are several ways to file a claim:

- **Claims Crossover (Medical FSA only):** Because your FSA is tied directly to your UnitedHealthcare medical plan, employees are automatically reimbursed for eligible expenses, such as copayments for clinic visits or prescriptions, through our automatic claim's rollover process. This means you will not need to fill out and submit any paperwork or documentation.
- **FSA Debit Card:** as an alternative to the Claims Crossover benefit, you may utilize an FSA debit card that automatically deducts eligible expenses at the point of service. In some cases, claims substantiation may still be required and may be sent UnitedHealthcare.
- **Manual Submission:** claims not sent via crossover or paid with a debit card can be submitted using any of the following methods:
- **Online:** log onto your account at myuhc.com and fill out an online claim form. Provide supporting documents with a copy of the online form to UnitedHealthcare.

How Claims Crossover Works



FLEXIBLE SPENDING ACCOUNTS (FSA)

How Does a Flexible Spending Account Help You Save Money?

If you enroll in one or both of the reimbursement accounts, your elected contributions will be deducted from your pay and will not be subject to federal Income Tax, State Income Tax, or Social Security (FICA) Taxes. When your taxable income is reduced, your taxes are also reduced.

The contributions you designate for flexible spending account (Health Care and Dependent Care) will be credited to a bookkeeping account on your behalf. This account will be used to reimburse you for eligible health care/dependent care expenses for you and your eligible dependents which are not reimbursed by another source, like insurance, another reimbursement plan, or a state agency.

The paycheck example provided below will give you an idea of the tax savings provided under the program, for a married person earning $36,000 per year, who elects $1,200 to the health care plan, and $3,600 to the dependent care plan.

	Paying your expenses pre-tax using the Flex Spending Account	Paying your expenses after-tax without using the Flex Spending Account
Gross Biweekly Pay	$1,500.00	$1,500.00
Health Care FSA	-$50.00	$0
Dependent Care FSA	-$150.00	$0
Gross Taxable Earnings	$1,300.00	$1,500.00
Federal Income Tax (15%)	-$195.00	-$225.00
State Income Tax (6%)	-$78.00	-$90.00
Social Security Tax (7.35%)	-$95.55	-$110.25
After Tax Health Care Expenses	$0	-$50.00
After Tax Daycare Expenses	$0	-$150.00
Net Biweekly Pay	$931.45	$874.75
Per Paycheck (Net) Savings	$56.70	
Yearly Tax Savings	$1,360.80	

Your debit card from UnitedHealthcare is an easy way to pay from your FSA

You can use it to pay by phone, the Web, or at any eligible provider or merchant that accepts MasterCard. Here are some of the highlights:

- It is connected to your flexible spending account (FSA).
- There is no need to write checks or submit claim forms.
- Use it for eligible medical, dental, vision and pharmacy expenses.
- Use it for eligible dependent care expenses (if it applies).

I've lost my card, or it was stolen!

Call Customer Care immediately at (866) 755-2648. We will deactivate the card immediately and will mail you a new card. If you report the missing card to us within four (4) business days, you will not be liable for any fraudulent use. You may be responsible for up to $50 if you do not report the loss within those four days. Be sure to monitor your account regularly on myuhc.com.

HEALTH SAVINGS ACCOUNT (HSA)

Account Administrator: OptumBank
Phone: (866) 234-8913
Website: www.optumbank.com

What is an HDHP-HSA Medical Plan?

An HDHP-HSA is a Medical Plan that combines a high deductible health plan with a savings account that offers you lower premium deductions from your paychecks and an opportunity to set aside pre-tax dollars to pay for future health care expenses. As long as those dollars are used to pay eligible health care expenses, you do not have to pay taxes on those funds. You may also invest your funds in a brokerage account once your account reaches certain levels, and investment earnings on your account grow tax-free.

How does the HSA Plan work?

- Your health plan provides first-dollar coverage for preventive care, such as routine physicals, screening tests, well childcare and prenatal care.
- Other expenses are subject to the medical plan deductible until you have reached the annual out-of-pocket maximum, and then your expenses are covered at 100%.
- When you enroll in the HSA, you will receive two (2) free VISA debit cards that you can use to pay for medical out-of-pocket expenses (e.g., at your doctor's office, at a retail pharmacy, etc.). If your doctor or hospital bills you for any services, you can provide your debit account information to the provider and the amount will be deducted from your debit account balance.
- If you pay your bill directly using another account outside the HSA, you can also obtain a reimbursement from your HSA account direct deposited to your checking or savings account

Who provides service for my HSA Account?

Your HSA Account is administered by Optum Bank. Optum Bank started operating on July 21, 2003. .

Optum Bank is part of Optum Financial and is a unit of Optum, a health and wellness company serving more than 115 million people. Optum is part of the UnitedHealth Group family of companies.

How is my HSA Invested?

Optum Bank offers a diverse set of mutual funds that average a four-star Morningstar rating and represent some of the lowest expense ratios in the industry. Once your HSA reaches the certain investment threshold, typically $2,000, you may choose to invest a portion of your HSA dollars in mutual funds.

Optum Bank mutual funds include:

- Vanguard funds
- Target date funds
- Lifestyle funds

When you set up your Optum Bank investment account, you can choose how you want the funds to be allocated among the available mutual funds. Our asset allocation calculator can help you decide which funds are right for you. There is no minimum initial investment amount required by mutual funds.

- You have the ability to transfer between funds and re-allocate balances
- You may set up automatic portfolio rebalancing
- If a qualified medical expense comes up, it is easy to move money back to your HSA cash account to pay for it
- After your account is established, you can change your investment elections, transfer funds, and rebalance your account

HEALTH SAVINGS ACCOUNT (HSA)

How much money can I contribute to a Health Savings Account (HSA)?

If you participate in the Plan Three, you will be eligible to participate in the HSA and contribute up to the annual limits that are established by the federal government. Contributions that are made through payroll deductions will be made pre-tax. Note: benefits are pro-rated for the period of time during which you are covered by an HSA–compliant medical plan):

2026 Calendar Year	Annual Maximum
Employee Only Coverage	$4,400*
Family Coverage	$8,750*
Additional Catch-up Contribution (Only available if you are age 55 or older)	$1,000

**Annual Maximums include contributions from all sources: examples would be pre- and post-tax contributions.*

How do I make my own contributions to the Health Savings Account?

You can elect to have your HSA contributions deducted from your pay on a before-tax basis, or you can make deposits directly to your HSA account and deduct those contributions from your taxable earnings when you file your taxes. If you choose to make deposits to the HSA outside of payroll deductions, there is a special form you must complete – Form 8889 – when you prepare your taxes.

Unlike traditional plans with a Flexible Spending Account, your unused HSA account balances roll over from year to year (there is no "use it or lose it" requirement). Your account is also portable, meaning that if you retire or leave Minneapolis Public Schools, you can still use your HSA to pay for qualified medical expenses (including COBRA or retiree medical insurance premiums).

Are there any other rules that apply to an HSA?

Because of the tax-favored treatment provided under HSA's, there are some restrictions on participation:

- You must participate in a health plan that meets certain standards (set by the Treasury Department) for minimum deductibles and out-of-pocket maximums. Plan Three offered with the MPS HSA plan meets those minimum standards.
- You cannot be covered under another health plan that would treat the same expenses as eligible for reimbursement. For example, if you are also covered under your spouse's health plan, you are not eligible for the health savings account.
- **If you elect to participate in the MPS HSA, you will not be eligible to participate in the Health Care Flexible Spending Account.** You will however be eligible to participate in the Dependent Care Reimbursement Account.
- If you take a withdrawal from your HSA for a purpose other than to pay for eligible medical expenses, that amount is subject to income taxes, as well as a 20% federal penalty tax.

Participants will receive IRS forms 5498 and 1099 to aid in tax preparation. The participant is responsible for documenting that all withdrawals have been used for qualified medical expenses and they will be liable for state and federal taxes if the expenses were not qualified medical expenses.

EMPLOYEE WELL-BEING PROGRAM

Carrier: The Vitality Group
Phone: (877) 224-7117
Website: www.powerofvitality.com

Investing in your personal and professional well-being

Vitality is a health and well-being platform that offers incentives for investing in your personal well-being. All benefit-eligible employees and their covered spouse are eligible to participate. Choose from a variety of wellness offerings including, physical activity, nutrition courses, financial fitness, workout challenges and more!

How to get started:

Go to www.powerofvitality.com and click on the link "First Time Logging In? Register Now." to create your account. You will then answer a few security questions that MPS has set up to ensure your account is accurate – this includes your full name, date of birth and the last four of your social.

Confidential well-being:

Vitality ensures the security of your data and will never share or sell your information. None of the information in Vitality is accessible to your employer. Rest assured; Vitality takes your privacy and security very seriously.

What you can earn through Vitality:

1. If you take the district's health insurance, you can earn the preferred wellness rate on your medical plan This means that you will receive the lowest level copays or deductibles on health insurance year over year. Employees have between January 1 and mid-October to reach silver status in Vitality in order to earn or maintain the wellness rates on health insurance.

***All new employees hired AFTER June 1st of the current calendar year automatically receive the wellness rate. Year-to-year, your participation will help you maintain the lower copays or deductibles on health insurance.*

2. All employees, regardless of insurance, can earn gift cards for their participation in Vitality. Every point is a penny, so the more points you earn the more bucks you can cash in for gift cards such as Amazon, Nike, REI and more! Your points never expire as long as you are a benefit-eligible employee at the district.

Where can I learn more:

Check out informational videos and more to help you get started on The Source: www.mpschools.org/the-source/apps-software/vitality or email wellness@mpls.k12.mn.us with questions.

***All new employees hired AFTER June 1st of the current calendar year automatically receive the wellness rate. Year-to-year, your participation will help you maintain the lower copays or deductibles on health insurance.*

On-demand fitness classes for improved health at home

WellBeats provides on-demand fitness classes for all benefit-eligible employees. Skip the gym and workout from the comfort of your own home with thousands of classes in addition to mindfulness meditations and healthy recipes.

How to get started:

On January 1, 2022, WellBeats was fully integrated with the Vitality platform for a seamless user experience. Employees can also get started by going to portal.wellbeats.com/#/idle and logging in with their MPS email address. Click on the "forgot password" link and an activation code will be sent to your MPS email.

Email wellness@mpls.k12.mn.us with any additional questions.

EMPLOYEE ASSISTANCE PROGRAM

Insurance Carrier: AllOne Health
Phone: (888) 243-5744
Website: allonehealth.com

Work-life balance - a benefit for you and your family

Your employee assistance program (EAP) is a problem-solving resource available to you and eligible members of your family. A professional counselor will help you assess your situation, identify options, make choices, and get additional help. When life happens, we are here.

It's free

Your employer pays for the initial assessment, the problem-solving sessions, and referral services. If more counseling or treatment is needed, your counselor will help you figure out your options.

It's confidential

Your EAP is set up with AllOne Health, an outside counseling resource, to ensure confidentiality. No one at work knows anything beyond what you choose to tell them. Nothing about your use of EAP appears in your employee personnel file.

It's convenient

Your EAP is as close as your phone. Our confidential intake process sets up face-to-face sessions with a licensed counselor near your work or home. Phone counseling services are also available.

It's voluntary

You know your life best, so contacting the EAP is only by your choice. A manager or co-worker might suggest you contact the EAP if you have talked about a complex problem with them, or they notice something is troubling you, but the decision to contact the EAP is always yours.

We are here to help

Your EAP provides free and confidential professional consulting, coaching, and counseling services for these and many other challenges:

- Chemical dependency
- Conflict resolution
- Coping with stress
- Depression, anxiety, and other mental health challenges
- Eldercare or childcare
- Financial troubles
- Grief and loss or change
- Legal concerns
- Parenting support
- Relationship concerns
- Work or career concerns

Download the AllOne Health App & Create Your New Account Today!

To access services through the new AllOne Health App, you must download the app and create a new account—even if you already use the member portal. When signing up, use your existing member portal Access Code: **MPSCHOOLS**.

Upcoming Live Webinars

Live webinars are scheduled throughout the year to provide information on important topics. For those unable to attend, recorded versions are made available in our library. To register for a webinar, visit allonehealth.com/webinars/ click the desired title and complete the linked registration form.

WELL@WORK CLINIC – DAVIS CENTER

Account Administrator: HealthPartners
Phone: (952) 967-7474
Website: www.HealthPartners.com

The medical clinic at the Davis Center is a partnership between MPS and HealthPartners that is managed by the Benefits Department. It provides conveniently located health care to MPS employees and their dependents at no charge. You do not have to have HealthPartners insurance through MPS to use the clinic. All benefits eligible employees and their qualified dependents may utilize the clinic's services.

The clinic will be staffed by a HealthPartners Nurse Practitioner or Physician's Assistant who can provide the following services onsite:

Medical	Lab Tests
Cold & Flu	Blood draws
Seasonal allergies	Blood pressure
Sinus infections	Cholesterol
Strep throat	Blood sugar
Pink eye	
Ear infections	
Back pain	
Sprains	
Stomach problems	
Women's health	
Vaccinations	

Many of the medicines commonly prescribed by the clinic will be available in generic form. This includes antibiotics, anti-inflammatories, blood pressure and cholesterol medications. Specialty and brand name drugs will not be available but can be filled through your local pharmacy. Narcotic pain medications also will not be available on-site.

Generic medications prescribed by the clinic will be provided to employees at no charge. The program is designed to save time and money by offering common medications on site and is not intended to replace your regular pharmacy.

Before you make your first appointment, be sure to register by calling the appointment center at the number listed below. Most appointments take about 20 minutes. **Visits are by appointment only.**

The clinic is open Monday through Wednesday from 7:00 AM to 5:00 PM, and Thursday through Friday from 6:00 AM to 2:30 PM. The clinic is closed on MPS recognized holidays.

Plan 3 Participants please note: Based upon IRS guidance, MPS has determined that the clinic provides significant medical benefits (other than preventive care) for our staff at no charge. **Any employee enrolled in Plan 3 will not be allowed access to the MPS clinic.**

BASIC LIFE AND AD&D

Insurance Carrier: Sun Life Financial
Phone: (800) 247-6875 (Customer Service & Claims)
Website: www.sunlife.com/us

Minneapolis Public Schools pays for basic life insurance for permanent employees working at least 20 hours a week or at least 0.5 FTE. Please refer to your collective bargaining agreement for the basic life insurance amount.

Employee Class	Base Term Life Amount	Base AD&D Amount
Superintendent	2x Basic Annual Earnings*	2x Basic Annual Earnings*
Non-Represented	$150,000	$150,000
Principals, Assistant Principals & Administrative Contracts	$100,000	$100,000
Administrators	$75,000	$75,000
Teachers, Tutors & Nurses	$100,000	$100,000
ESP	$45,000	$45,000
Food Service Workers	$35,000	$35,000
Janitor/Custodian/Engineering	$35,000	$35,000
All Other Employees	$20,000	$20,000

**Rounded to the next higher $1,000, if not already a multiple of $1,000. Maximum benefit is $750,000.*

This benefit also provides the following additional services:

- **Survivor Financial Counseling Services**
  This personalized financial counseling service provides expert, objective financial counseling to survivors and terminally ill employees at no cost to them. This service is also extended to employees upon the death or terminal illness of their covered spouse.
- **Sun life does not offer portability, only conversion**
  If you retire or leave MPS, you may be able to take your coverage with you in accordance with the terms outlined in the contract
- **Waiver of Premium**
  If you become disabled (as defined by the MPS plan) and are no longer able to work, your premium payments will be waived during the period of disability
- **Accelerated Benefit**
  If you become terminally ill and are not expected to live more than twelve months, you may request up to 50% of your life insurance amount up to 50% of your life insurance amount up to $750,00 without fees or present value adjustments

SUPPLEMENTAL LIFE AND AD&D INSURANCE

Insurance Carrier: Sun Life Financial
Customer Service: (800) 247-6875 (Customer Service & Claims)
Website: www.sunlife.com/us

	Employee	Spouse	Child[1]
Supplemental Life Coverage: provides a benefit in the event of death			
Schedule	Increments of $10,000	Increments of $5,000	Increments of $2,500
Guaranteed Issue	$250,000	$50,000	$10,000
Overall Benefit Maximum	$250,000	$100,000 Cannot exceed 50% of the employee's election	$10,000 Cannot exceed 50% of the employee's election
Age Reduction Schedule	Coverage reduces to 65% of the original amount at age 65, to 40% of the original amount at age 70 and to 20% of the original amount at age 75		N/A

Age*	Rates per $1,000	Supplemental Life Coverage Level Example Monthly Premiums For:					
		$10,000	$50,000	$70,000	$100,000	$200,000	$250,000
00 – 29	$0.06	$0.60	$3.00	$4.20	$6.00	$12.00	$15.00
30 – 34	$0.08	$0.80	$4.00	$5.60	$8.00	$16.00	$20.00
35 – 39	$0.09	$0.90	$4.50	$6.30	$9.00	$18.00	$22.50
40 – 44	$0.14	$1.40	$7.00	$9.80	$14.00	$28.00	$35.00
45 – 49	$0.25	$2.50	$12.50	$17.50	$25.00	$50.00	$62.50
50 – 54	$0.41	$4.10	$20.50	$28.70	$41.00	$82.00	$102.50
55 – 59	$0.70	$7.00	$35.00	$49.00	$70.00	$140.00	$175.00
60 – 64	$0.77	$7.70	$38.50	$53.90	$77.00	$154.00	$192.50
65 – 69	$1.30	$13.00	$65.00	$91.00	$130.00	$260.00	$325.00
70+	$2.06	$20.60	$103.00	$144.20	$206.00	$412.00	$515.00

**Premiums for Spousal Life Insurance are based on the spouses' age at the time of election.*

Dependent Child Coverage Monthly Premium	$0.308 / $2,500

LONG-TERM DISABILITY BENEFITS

Insurance Carrier: Sun Life Financial
Phone: (800) 247-6875 (Customer Service & Claims)
Website: www.sunlife.com/us

Employees in qualifying bargaining units* are automatically enrolled in the MPS Long-Term Disability plan, which is paid for by the District. In the event you become disabled, upon approval from the insurance carrier, the policy will provide a monthly benefit, after satisfaction of the elimination period, up to a maximum benefit per month. Check your collective bargaining agreement to determine the coverage and maximum amounts for your group.

Elimination Period:	90 - Consecutive days of Total Disability (refer to your policy booklet for details)
Definition of Total Disability:	During the elimination period and the next 24 months, the Employee, because of injury or sickness, is unable to perform the Material and Substantial Duties of his Own Occupation. After Total or Partial Disability benefits combined have been paid for 24 months, the employee will continue to be Totally Disabled if he is unable to perform with reasonable continuity any Gainful Occupation for which he is or becomes reasonably qualified for by education, training, or experience.
Monthly Benefit:	60% - 66.67% of the employee's covered monthly earnings (varies per union) refer to your policy booklet for details).
Maximum Monthly Benefit:	Varies per union (refer to your policy booklet for details).
Definition of Covered Monthly Earnings:	The Employee's basic monthly earnings as reported by the Employer immediately prior to the first date Total or Partial Disability begins. Total Monthly Earnings does not include commissions, bonuses, overtime pay or any other extra compensation.
***Qualifying Bargaining Units:**	Teachers, Principals, AFSCME, AMP, Non-Representative, MAAS, MACA, Teamsters-Grounds, Teamsters-Drivers, ESP.

Benefit Duration	
Age at Disability	**Maximum Benefit Period**
>60	To age 65, but not less than 60 months
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Minnesota Paid Family Medical Leave

Starting in 2026 the state of Minnesota will begin offering Minnesota Paid Family Medical Leave!

Minnesota Paid Leave is a state-run program that helps workers take time off for major life events serious illness or welcoming a new child. Funded by both employers and employees, it works like insurance. If approved, you'll receive partial wage replacement during your leave, and your job will be protected until you return. For more information, visit the state website at mn.gov/deed/paidleave/employees/.

ADDITIONAL SUN LIFE BENEFITS

Travel Assistance:

If you have a medical emergency while traveling 100 miles or more away from home, you do not have to face it alone. With one phone call, you can be connected to Assist America's staff of medically trained, multilingual professionals who can advise you in a medical emergency, 24 hours a day, 7 days a week.

You will be immediately connected to:

- Pre-qualified, English-speaking doctors, hospitals, pharmacies, and dentists anywhere in the world
- Medical consultation, evaluation, and referral
- Hospital admission guarantee
- Emergency medical evacuation
- Loss Prevention assistance
- Legal and interpreter services

Identity Theft Solutions:

You have the support of a powerful identity theft program through Assist America's Secure-Assist Identity Protection Program. It provides:

- 24-hour, 7 day a week telephone support and step-by-step guidance provided by anti-fraud experts
- An expert case worker who is assigned to you and will help you notify your credit bureaus and file paperwork to correct your credit reports
- Help in canceling stolen credit cards and reissuing new cards
- Help in notifying police, financial institutions, and government agencies

LONG-TERM CARE INSURANCE

Insurance Agency: Newman Long Term Care
Phone: (612) 454-4400
Website: www.newmanlongtermcare.com

Long-term care insurance (LTCI) helps cover the high costs of personal and custodial care when you can no longer perform everyday tasks, like bathing or dressing, due to chronic illness, disability, or cognitive impairment (like dementia). It pays for services in various settings, including your home, adult day care, assisted living, or a nursing home, and protects your savings by paying a monthly benefit (up to policy limits) for care not typically covered by health insurance or Medicare.

To provide a variety of insurance solutions, Minneapolis Public Schools has partnered with Newman Long Term Care, a local agency specializing in long-term care since 1990. They offer solutions from strong and stable insurers such as Thrivent, Mutual of Omaha, National Guardian Life, Nationwide, OneAmerica, Lincoln MoneyGuard, Brighthouse and Securian. They have helped over 50,000 families create extended care plans. Their LTCI Specialists can design solutions for just about any budget and will work with you to determine what type of insurance might best suit your future care needs. Contact their team today to request a free planning discussion.

Benefit	Benefit Details
Benefit Maximum	Up to a maximum $100, or $200 if filing jointly
Eligibility	Employee, spouse, parents, grandparents, and in-laws are eligible.
Benefit Cost	Premiums are per person and based upon age and the effective date of coverage. Premiums are paid with after-tax dollars and do not change unless you increase your benefits

The Need for Long-term Care Insurance

Under the age 65, common causes are cancer, complications of surgery, spinal cord injury, brain damage from accidents and strokes, and Multiple Sclerosis. Over the age 65, common causes are diabetes, fractures and falls, emphysema, stroke, influenza, and Alzheimer's disease.

403(B) & 457 TAX-DEFERRED SAVINGS PLAN

403(b) & 457 Plan Administrator:
Corebridge Financial
Contacts:

- North Schools - Shea Murphy (651) 356-2285
- Central Schools - Joshua Nokes (651) 955-4266
- South Schools - Cameron Strobel (612) 710-6194
- East Schools - Eric Gross (612) 900-6483

Website: www.corebridgefinancial.com/rs/mps

457 Plan Administrator: MSRS
Contacts:

- Mary Voss (651) 335-5397
  Mary.voss@mnretire.gov

Website:
www.mnretire.gov

Starting to save early can make a significant difference in reaching your retirement goals. Minneapolis Public Schools Tax-Deferred Savings plans are an easy way to invest pre-tax earnings to build the level of income you will need for a secure financial future. MPS allows employees to participate in a 403(b), a Roth 403(b), a 457 Roth or a 457 Plan.

Contributions

All contributions to the 403(b) and 457 plans are made on a pre-tax basis. This reduces your taxable income at the end of the tax year. All gains are tax deferred until you withdraw them for retirement. Contributions to the Roth 403(b) and Roth 457 plans are made on an after-tax basis.

You may contribute to these savings plans at any time, and they do not require any type of participation eligibility. These accounts also allow for an MPS match up to an annual dollar amount. That means that MPS will contribute one dollar for every dollar you contribute up to an annual maximum amount. Check your collective bargaining agreement for more information on your group's matching amounts.

The Internal Revenue Code limits the amount that you can contribute to the account in a calendar year. At no time may you go over the elective deferral limit for the year. Employees are responsible for monitoring their contribution limit each year.

The Tax-Deferred Savings arrangement offers eligible employees the opportunity to direct voluntary contributions to one or both recognized MPS carriers, Corebridge and MSRS.

DEFINED BENEFIT PENSION PLANS

MPS employees are covered by two (2) Defined Benefit Pension plans:

- Public Employee Retirement Association (PERA)
- Teacher Retirement Association (TRA) – Licensed employees

Contributions are made jointly by MPS and the employee in accordance with formulas established by the respective agency and State law. The plans are administered by the respective agency and funds held and distributed by them.

For more information on the plans and account balances, employees should contact:

Public Employee Retirement Association (PERA)
Customer Service
www.mnpera.org
(800) 652-9026

Teacher's Retirement Association (TRA)
Customer Service
www.minnesotatra.org
(800) 657-3669

Minnesota 529 College Savings Plan

The Minnesota 529 Plan is an easy way to help you prepare for your children's college education. These plans are individual investment accounts that offer tax incentives to save for higher education and training. An account can be established for a designated beneficiary and after-tax contributions are then automatically deposited through an automatic deduction from your bank account. When the money is withdrawn for qualified education expenses, there are no state or federal taxes on the earnings of this account.

Other advantages include:

- Choice of schools – Whether your child decides to go to private or public college/University, trade, or graduate school, in Minnesota or another state, funds in your account may be used at any eligible educational institution. Your savings can be used for tuition as well as related qualified expenses such as books, fees, certain room and board expenses, and supplies and equipment required for enrollment or attendance.
- Anyone can contribute – Parents, grandparents, relatives, and friends at any income level may open an account and contribute.
- You are in control – You maintain control of the funds in the account. Your child or beneficiary cannot spend the money on a non-qualified expense.
- Low minimum contribution – An account may be opened with $25.

For enrollment information go to **www.mnsaves.org** at (877) 338-4646 or contact Emmanuel Torres at (952) 830-3111, email **Emmanuel.Torres@tiaa.org**.

LEGAL SERVICES

Carrier: LegalShield
Phone: (651) 353-6568
Website: www.legalshield.com/info/mpls

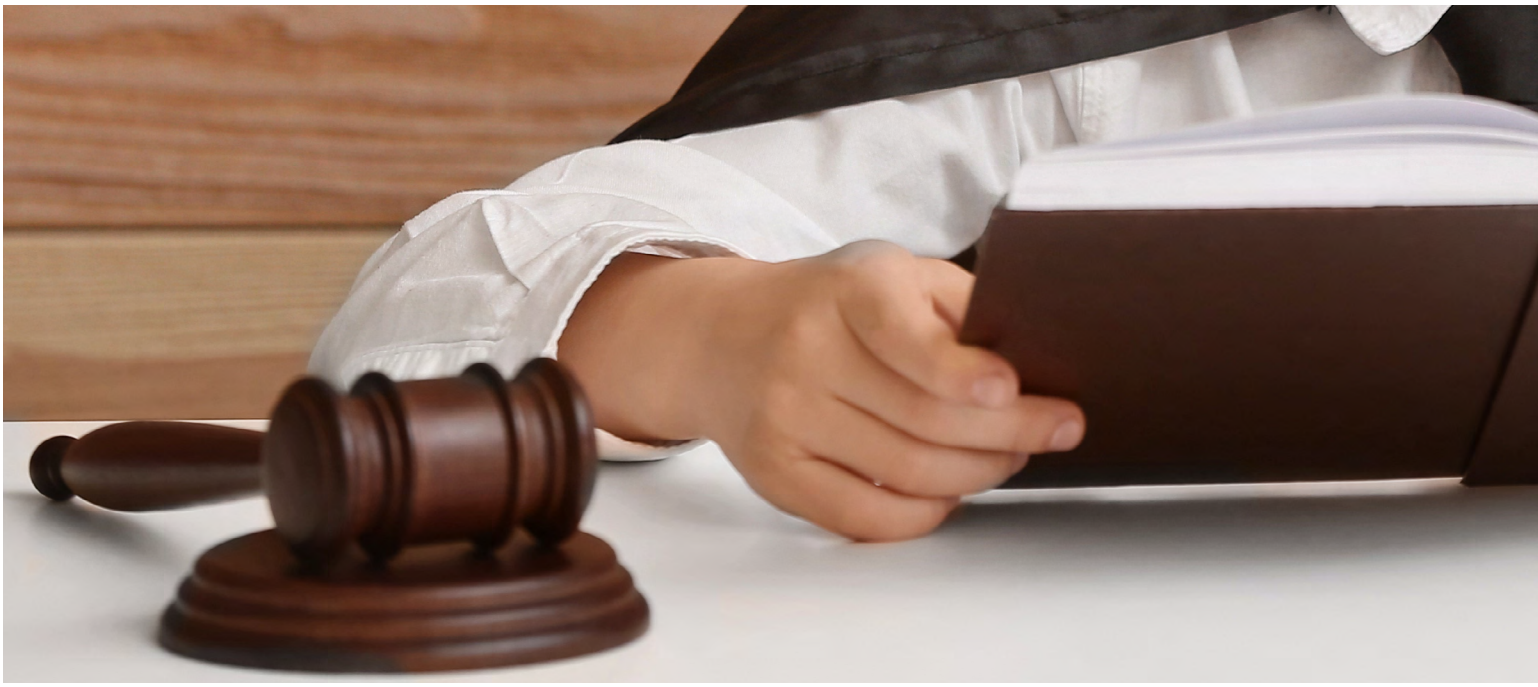
What is LegalShield?

LegalShield was founded in 1972, with the mission to make equal justice under law a reality for all North Americans. The 3.5 million individuals enrolled as LegalShield members throughout the United States and Canada can talk to a lawyer on any personal legal matter, no matter how trivial or traumatic, all without worrying about high hourly costs. LegalShield has provided identity theft protection since 2003 with Kroll Advisory Solutions, the world's leading company in ID Theft consulting and restoration. We have safeguarded over 1 million members, provided more than 200,000 identity consultations, and helped restore nearly 10,000 individual identities.

The LegalShield® Membership Includes:

- Legal Advice – personal legal issues
- Letters/calls made on your behalf
- Contracts & documents reviewed (up to 15 pages)
- Residential Loan Document Assistance
- Attorneys prepare your Will, your Living Will and your Health Care Power of Attorney
- Moving Traffic Violations (available 15 days after enrollment)
- Trial Defense including Pre-Trial & Trial
- Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)
- IRS Audit Assistance
- 25% Preferred Member Discount (Bankruptcy, Criminal Charges, Other Matters, etc.)
- 24/7 Emergency Access for covered situations

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under age 18 for whom the member is legal guardian; never married, dependent children up to age 26 if a full-time college student; and physically or mentally disabled dependent children.



LEGAL SERVICES

The IDShield℠ Membership Includes:

Full-Service Restoration
Complete identity recovery services by Kroll Licensed Private Investigators and our $5 million service guarantee ensure that if your identity is stolen, it will be restored to its pre-theft status.

Security Monitoring
SSN, credit cards (up to 10), and bank account (up to 10) monitoring, sex offender search, financial activity alerts and quarterly credit score tracking keep you secure from every angle.

Privacy Monitoring
Monitoring your name, SSN, date of birth, email address (up to 10), phone numbers (up to 10), driver license & passport numbers, and medical ID numbers (up to 10) provides you with comprehensive identity protection service that leaves nothing to chance.

Consultation
Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection.

IDShield plans are available at individual or family rates. A family rate covers the member, member's spouse and up to 8 dependents up to the age of 18.

Monthly Rates (Premiums Paid via Bank Draft/Credit Card)			
	LegalShield	IDShield	Combined
Individual Coverage	$20.95	$12.95	$33.90
Family Coverage	$20.95	$22.95	$40.90

This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See a plan contract for your state of residence for complete terms, coverage, amounts, conditions, and exclusions. 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.

CARRIER CONTACT INFORMATION

Vendor	Benefit	Telephone Number	Website
UnitedHealthcare	Health Insurance Flexible Spending Accounts	(866) 633-2446	www.myuhc.com
Delta Dental of MN	Dental Insurance	(651) 406-5916 (800) 553-9536	www.deltadentalmn.com
Optum Bank	Health Savings Account	(866) 234-8913	www.optumbank.com
VSP	Vision Insurance	(800) 877-7195	www.VSP.com
Sun Life Financial	Life Insurance	(800) 247-6875	www.sunlife.com/us
Newman	Long-term Care Insurance	(612) 454-4400	www.newmanlongtermcare.com
Corebridge Financial	403(b) & 457 Savings Plans	(651) 356-2285 (North Schools) (651) 955-4266 (East Schools) (612) 710-6194 (South Schools) (612) 900-6483 (Central Schools)	www.corebridgefinancial.com/rs/mps
MSRS	457 Savings Plan	(651) 335-5397	www.mnretire.gov
MN Public Employee Retirement Association (MNPERA)	Defined Benefit Pension Plans	(800) 657-5757	www.mnpera.org
Teachers' Retirement Association (TRA)		(800) 657-3669	www.minnesotatra.org
Minnesota Office of Higher Education	529 College Savings Plan	(877) 338-4646 or (952) 830-3111	www.mnsaves.org or via email: Emmanuel.Torres@tiaa.org
AllOne Health	Employee Assistance Program	(888) 243-5744	allonehealth.com
Legal Shield	Legal Assistance & Identity Protection	(651) 353-6568	www.legalshield.com/info/mpls

CHILDREN'S HEALTH PROGRAM (CHIP)

Medicaid & CHIP

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from MPS, 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 are not eligible for Medicaid or CHIP, you will not 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 MPS's plan, MPS must allow you to enroll in the medical plan if you are not 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 MPS's Plan, contact the Department of Labor at **www.askebsa.dol.gov** or call (866) 444-EBSA (3272).

Below is contact information for state agencies that can help determine whether you are eligible for assistance paying your employer health plan premiums.

State	Agency	Phone	Website
MN	Medicaid	800-657-3739	https://mn.gov/dhs/health-care-coverage/
WI	Medicaid	800-362-3002	https://www.dhs.wisconsin.gov/badgercareplus/hipp.htm

You can also obtain a copy of the full listing from the Department of Labor website or by clicking this link to the **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)**

For more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human Services
Employee Benefits Security Administration
www.dol.gov/ebsa
(866) 444-EBSA (3272)

COBRA CONTINUATION COVERAGE

Introduction

You are receiving this notice because you have recently become covered under the Minneapolis Public Schools Group Health Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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 to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Claims Administrator for each plan subject to COBRA Continuation Coverage is as follows:

Medical Plan:	UnitedHealthcare
Dental Plan:	Delta Dental of Minnesota
Vision Plan:	VSP
Health Care Flexible Spending Account:	UnitedHealthcare

The Plan Administrator is Minneapolis Public Schools. COBRA administrative services are outsourced to UHC Benefit Services. For information about your COBRA continuation rights, contact the Benefits Department at the address shown on the Welcome page, which is the first page of this booklet.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct
3. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:
   - 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 enrolled in Medicare (Part A, Part B, or both); or
   - You become divorced or legally separated from your spouse.
4. Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
   - 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 enrolled in Medicare (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."

COBRA CONTINUATION COVERAGE

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), you will receive notice of your continuation rights within 45 days of the date coverage ends.

You Must Give Notice of Some Qualifying Events

For the 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. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the Benefits Department at the address shown on the Welcome page, which is the first page of this booklet.

How is COBRA 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. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or the reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

COBRA CONTINUATION COVERAGE

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must send this notice to the Benefits Department at the address shown on the Welcome page, which is the first page of this booklet.

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and, dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. You must send this notice to the Benefits Department at the address shown on the Welcome page, which is the first page of this booklet.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact MPS at (612) 668-0560, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

NOTICE OF PRIVACY PRACTICES

For the Group Health Plans Maintained by Minneapolis Public Schools

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA. We have prepared this explanation of how the Plan(s) are required to maintain the privacy of your health information and how the Plan(s) may use and disclose your health information. The Plan(s) may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.
- **Health care operations means** such business-related activities as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review. However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

As permitted or required by law. The Plan(s) may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. The Plan(s) permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. The Plan(s) are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. The Plan(s) will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, the Plan(s) will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. The Plan(s) may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. The Plan(s) may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, the Plan(s) may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

NOTICE OF PRIVACY PRACTICES

To the Plan Sponsor

The Plan(s) may disclose protected health information to certain employees of The Printer, Inc. for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

The Plan(s) may also create and distribute de-identified health information by removing all references to individually identifiable information. The Plan(s) may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and the Plan(s) are required to honor and abide by that written request, except to the extent that the Plan(s) have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. The Plan(s) are not, however, required to agree to a requested restriction. If the Plan(s) do agree to a restriction, the Plan(s) must abide by it unless you agree in writing to remove it.
- We will agree to your requested restrictions if: (1) except as otherwise required by law, the disclosure is to a health plan for purposes of payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.
- The right to reasonable requests to receive confidential communications of protected health information from the Plan(s) by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of non-routine disclosures of protected health information.
- If your PHI is maintained in an electronic health record, you are entitled to a copy of the information in an electronic format and you may direct us, in a clear and specific manner, to transmit such copy to a designated entity or person.
- If your PHI is maintained in an electronic health record, the accounting will reflect disclosures for the purposes of treatment, payment, and health care operations.
- You have the right to be notified in the event that we (or our business associates) discover a breach involving your PHI that is unsecured.

The Plan(s) have the obligation to provide, and you have the right to obtain a paper copy of this notice from the Plan(s) at least every three years. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The Plan(s) are required to abide by the terms of the Notice of Privacy Practices currently in effect. The Plan(s) reserve the right to change the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that is maintained. The Plan(s) will post, and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions.

NEW HEALTH INSURANCE MARKETPLACE

When key parts of the new health care law took effect in 2014, there was 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 MPS.

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. Open enrollment for health insurance coverage under the Marketplace begins November 1, 2026 for coverage starting on December 15, 2026.

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 that does not meet certain standards. The savings on your premiums that you are eligible for depends upon 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 means certain standards. If the cost of a plan from your employer that would cover you (and not only any other members of your family) is more than 9.56% of your household income for the year, 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 credit.

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

If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you will lose the employer contribution 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?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Your employer CANNOT supply any information or guidance in regard to Marketplace benefits. Visit www.healthcare.gov for more information, including an application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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