LET'S TALK ABOUT YOUR 2025-26 BENEFITS

St Anthony New Brighton School District 282

St. Anthony New Brighton
INDEPENDENT SCHOOL DISTRICT 282

ENROLL FOR 2025 BENEFITS

BENEFITS OVERVIEW

St Anthony New Brighton School District 282 is proud to offer a comprehensive benefits package to eligible, full-time employees who work 20 hours per week. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical and dental), and St Anthony New Brighton School District 282 provides other benefits at no cost to you (life, accidental death & dismemberment). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

BENEFITS OFFERED

- Medical
- Dental
- Flexible Spending Account (FSA)
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D

ELIGIBILITY

You and your dependents are eligible for St Anthony New Brighton School District 282 medical and dental benefits on your date of hire. For the Life and Disability coverages, if eligible, your benefits will become effective the first of the month following your date of hire.

Eligible dependents are your legal spouse, children under age 26, and disabled dependents of any age.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days in order to make a change. In most cases, if you are outside of the 30-day window, you will have to wait until the following open enrollment to make a change.

BENEFITS PORTAL

All of the benefits information, including full plan summaries, enrollment forms, value-added services, links to carrier websites, and more, are located out on our online benefits portal. This portal is available while at work and when you are at home, so you can view this information whenever it works best for you. Simply type **c2mb.ajg.com/sanb282** into your web browser to access all our benefits materials and information.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal Law gives you choices about your prescription drug coverage.

MEDICAL **BENEFITS**

Administered by HealthPartners

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost. Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through St. Anthony New Brighton School District 282.

Online Resources

The number one way to engage with your medical plan throughout the year is via HealthPartners' online and mobile platforms. Once you have your ID card, simply go to **www.healthpartners.com** and register for your personalized *myHealthPartners* account. Through this account you can access all your claims information, view where you are at in satisfying your deductible, search the provider networks and prescription formulary, access the variety of wellbeing resources offered, and much more. Once you have created your online account, download the **HealthPartners mobile app** and use the same login information created for the online portal to access many of the same resources, right at your finger tips.

ID Cards

Employees can access, view and print their member ID card anytime, from any computer by signing into **www.healthpartners.com** and clicking on the "Member ID card" link. You may also utilize the **HealthPartners mobile app** using the same login as the online portal. Both are fast and convenient ways to show proof of health care coverage if you don't have your health insurance card readily available.

Virtuwell

Virtuwell is HealthPartners' online healthcare tool that can treat more than 65 common conditions. Simply go online to www.virtuwell. com and complete a short questionnaire. A Nurse Practitioner will then contact you with your treatment plan, and if necessary will send a prescription to the pharmacy of your choice. This service is available during regular clinic hours and **there is no cost to utilize Virtuwell!** Save a trip to Urgent Care and use Virtuwell instead!

Doctor On Demand

A telehealth option that is available 24/7, 365 days per year, is Doctor on Demand. Through this service, you are able to video chat with board-certified physicians who can look, listen, and interact with you through the mobile app or the internet. Doctor On Demand doctors can treat many of the top conditions for which you need to see a doctor such as urgent care, chronic conditions, mental health and more...see the full list of conditions at **www.doctorondemand.com/medical**.

Doctor on Demand also offers mental health care needs by staffing licensed psychiatrists and psychologists. You can schedule visits with the same provider, or to speak with the next available provider, whichever you prefer. Mental health visits are longer than medical visits, and thus the cost differs. However, Doctor on Demand is still a low cost, convenient option to receive care from the comfort of your own home.

Visit **www.doctorondemand.com** and download the Doctor on Demand app.

MEDICAL **BENEFITS**

Administered by HealthPartners

Network Options

You have the option to choose between two different network options, the **Open Access Network** or the **Achieve Network**. Regardless of which option you choose, the plan benefits (listed on the next page) and the prescription formulary remain exactly the same. In addition, both networks utilize the same national network through Cigna, so no matter where you are within the country, you will have access to in-network coverage through the Cigna providers. Again, the national network is the same under both network options.

Open Access

The Open Access network is the largest, most broad network the HealthPartners has to offer, and includes all the major hospitals and care systems in Minnesota, including Mayo Clinic. Approximately 98% of physicians and 100% of hospitals in MN participate in this network. To search the Open Access network, simply go to **www.healthpartners.com/openaccess**, or by calling **Member Services** at 952.883.5000 or 800.883.2177.

Achieve

The Achieve network is a slightly narrower network and focuses primarily on the HealthPartners and Park Nicollet family of clinics and care systems, as well as several independent clinics, and many area hospitals. The chiropractic providers and mental health providers are the same as the Open Access network. You can search providers in your network by logging **www.healthpartners.com/achieve** or by calling **Member Services** at 952.883.5000 or 800.883.2177.

Summary of Benefits and Coverage

Employees may view the Summary of Benefit and Coverage (SBC) for the HealthPartners health insurance plan design offered through St. Anthony New Brighton School District 282. The SBCs are located on the benefits portal for your review. Simply go to **c2mb.ajg.com/sanb282** and review all the benefits information located there.

MEDICAL
BENEFITS (Continued)

Administered by HealthPartners

Plan	$1,500 VEBA Plan
In-Network Plan Design Features	
Lifetime Benefit Maximum	Unlimited
Plan Year Deductible	$1,500/ Single $3,000 / Family
Coinsurance	0% after deductible
Plan Year Out-of-Pocket Maximum	$1,500/ Single $3,000 / Family
District VEBA Contribution	$550/ Single $1,100 / Family
Doctor's Office	
Preventive Care	100% Coverage
Office Visit and Urgent Care	0% after deductible
Convenience / Retail Care Clinic	0% after deductible
Lab, Pathology ,X-Ray	0% after deductible
Inpatient and out patient hospitalization	0% after deductible
Emergency Room Facility	0% after deductible
Prescription Drugs (RX)	
Generic	0% after deductible
Formulary	0% after deductible
Specialty Drugs	0% after deductible
Employee Premium (Per Pay Period)*	**Open Access Network**
Single	$90.65
Family	$268.53
Employee Premium (Per Pay Period)*	**Achieve Network**
Single	$78.38
Family	$232.28

*Premium rates are based on an employee with a 73%-100% FTE status. If you are a different FTE status, please see your cost sheet for the per pay period cost of your coverage. Cost sheets are available on our online benefits portal or by contact District Human Resources.

MEDICAL INSURANCE **TERMINOLOGY**

Deductible

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

Coinsurance

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

Out-of-Pocket Maximum (OOPM)

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

Explanation of Benefits (EOB)

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

Health Reimbursement Arrangement/ Voluntary Employees Beneficiary Association (HRA / VEBA)

A tax-free medical expense account funded by the District on your behalf if you enroll in the $1,500 VEBA medical plan. The District funds your VEBA account in October and February of each year.

In-Network

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

Out-of-Network (OON)

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

Certificate of Coverage (COC)

The Certificate of Coverage is a summary of the master plan document. This document will be made available each year shortly after July 1. You may receive your COC by contacting HealthPartners' Member Services, you're the District benefits team, or by logging into your account at www.healthpartners.com.

Formulary Drugs

Formulary drugs are the prescription medications covered under your medical insurance with the maximum plan benefit. If your provider prescribes a non-formulary medication, you will have coverage, but a higher copay will be assessed. Please see the complete Formulary Drugs List available at www.healthpartners.com, click on "Pharmacy," then "Search our formularies" and then "PreferredRx Formulary."

FLEXIBLE SPENDING ACCOUNTS

Administered by Mid-America

You can save money on your healthcare and/or dependent day care expenses with an FSA. You set aside funds each pay period on a pre-tax basis and use them tax-free for qualified expenses. You pay no taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

The Flexible Spending Account allows you to set aside "pre-tax" dollars to pay for:

- Dependent Care Expenses (up to a maximum of $5,000 per year)
- Health Care Reimbursement (up to a maximum of $3,300 per year)

Here's How an FSA Works

1. You decide the annual amount (up to the above listed maximum for each account) you want to contribute to either or both FSAs based on your expected healthcare and/or dependent childcare/elder care expenses.
2. Your contributions are deducted from each paycheck before taxes, and deposited into your FSA.
3. You can pay with the Healthcare FSA debit card for eligible healthcare expenses. For dependent care, you pay for eligible expenses when incurred, and then fi le the claim online.
4. You are reimbursed from your FSA. So, you actually pay your expenses with tax-free dollars.

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

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

FSA		
	Without FSA	With FSA
Gross Pay	$24,000	$24,000
Less Premiums and FSA Contributions	$0	$3,500
Taxable Income	$24,000	$20,500
Less Taxes	-$7,200	-$6,150
Less Out-of-Pocket Expenses	-$3,500	-$3,500
Plus Reimbursement from FSA	$0	+$3,500
Take-Home Pay	$13,300	$14,350

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

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

Carryover Provision: If you have money leftover in the **Healthcare FSA** at the end of the plan year, **up to $640** will carryover from the 2024-25 plan year into the 2025-26 plan year. The amount carried forward will be available following the 90-day runout period. The Dependent Care FSA does not have a carryover provision.

DENTAL BENEFITS

Administered by HealthPartners

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the St Anthony New Brighton Schools' dental benefit plan.

HealthPartners is our plan administrator. Please refer to the schedule below for a summary of the benefits. After you have satisfied the deductible (if applicable) your dental plan pays the following percentages of the treatment costs, up to a maximum fee per procedure. The maximum fee allowed by HealthPartners is different for in-network dentists and out-of-network dentists. If you see an out-of-network dentist your out-of-pocket expenses may increase.

Dental Plan Through HealthPartners			
	In-Network Level 1	**In-Network Level 2**	**Out-of-Network**
Annual Maximum	$1,250	$1,250	$1,250
Deductible (Single / Family)	**None**	$25 / $75	$25 / $75
Implant Maximum	$625	$625	$625
Preventive/ Diagnostic Care			
Cleanings/Exams (2x per year), Dental X-rays, Fluoride Treatments	You Pay Nothing		
Sealants	No Coverage		
Basic I Services			
Fillings (amalgam and anterior composite)	**You Pay Nothing**	You Pay 20%	You Pay 20%
Posterior Composite (White Fillings)	**You Pay 20%**	You Pay 50%	You Pay 50%
Simple Extraction	You Pay 20%	You Pay 20%	You Pay 20%
Non Surgical Periodontics	You Pay 20%	You Pay 20%	You Pay 20%
Endodontics (root canal therapy)	You Pay 20%	You Pay 20%	You Pay 20%
Basic II Services			
Surgical Periodontics	You Pay 20%	You Pay 20%	You Pay 20%
Complex Oral Surgery	You Pay 20%	You Pay 20%	You Pay 20%
Special Care			
Restorative Crowns & Onlays	You Pay 50%	You Pay 50%	You Pay 50%
Prosthetics			
Bridges, dentures & partial dentures	You Pay 50%	You Pay 50%	You Pay 50%
Dental Implants	You Pay 50%	You Pay 50%	You Pay 50%
Orthodontics (dependents age 8-18)			
Orthodontic care	You Pay 50%	You Pay 50%	Plan You Pay 50%
Orthodontia Lifetime Maximum	$1,000	$1,000	$1,000

DENTAL BENEFITS

Benefit Maximums

The Plan pays up to a maximum of $1,250 for each covered person per calendar year, subject to the coverage percentages identified below. Please Note: Any amount the Plan pays for Diagnostic and Preventive Services goes towards the Annual Maximum, even though there is no cost to you for those services.

Deductible

Your deductible will be determined based on which benefit level your provider is contracted in. The deductible does not apply to Diagnostic and Preventive Services, and Orthodontia Services. For exact coverage terms and conditions, consult your plan materials.

HealthPartners Dental Distinctions Network

HealthPartners Dental Distinctions network categorizes their in-network providers into two benefit levels (Level 1and Level 2). Seeing a provider that is in Level 1will provider you some additional benefits (no deductible, increase coverage for certain basic services such as fillings). Level 1providers also have the deepest discounts on services, which will help your annual maximum go just a bit further. You do not need to select the benefit level when you enroll in the plan, this is simply determined at the point of service depending on which level your provider is in.

Search the Network

Simply go to **healthpartners.com/dentaldistinctions** and search for a dentist or clinic near you! You may also call **Member Services** at 952.883.5000 or 800.883.2177.

Dental Plan Costs

Employee Premiums Per Pay Period		
	Teachers	**Non-Teachers**
Single	$2.48	$2.13
Family	$8.33	$9.93

DISTRICT-PAID **INSURANCE**

Administered by The Hartford

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by St Anthony New Brighton School District 282. The District provides basic life insurance **at no cost to you**. Benefits differ based on your employment class. Please refer to the applicable plan summary located on the benefits portal for your benefit amount.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. This coverage is in addition to your District-paid life insurance described above, and is in the same amount of coverage based on your employment class.

Long-Term Disability

Meeting your basic living expenses can be a real challenge if you become disabled. Long-Term Disability coverage provides a partial replacement of monthly earnings to an individual who becomes disabled for an extended period of time, due to accident or illness. That is why the District provides Long-Term Disability coverage **at no cost to you**.

Long-Term Disability coverage provides income when you have been disabled for 90 days or more. Your benefit is 66.67% of your monthly earnings, up to a maximum amount per month, determined by your employee class. This amount may be reduced by other sources of income or disability earnings. Please review the certificate of coverage for your employee class for more details.

Critical Illness

An unexpected critical illness can have a lasting impact on you and your family—physically, emotionally and financially. A critical illness insurance policy provides a lump-sum cash benefit upon diagnosis of a critical illness like a heart attack, stroke or cancer. The benefit can be used to pay out-of-pocket expenses or to supplement your daily cost of living. Depending on the illness you may be paid out 100%, 25% or a specified dollar amount (ie. $250 for Skin cancer).

The District provides this coverage to all employees covered by the Basic Life coverage **at no cost to you**.

Covered Conditions include, but are not limited to: Heart Attack, Cancer, Bone Marrow Failure, Benign Brain or Spinal Cord Tumor, Stroke, Aneurysm, and many more.

Please review the certificate of coverage for more details.

VOLUNTARY COVERAGE
TERM LIFE AND AD&D

Administered by The Hartford

You may purchase additional Term Life and AD&D insurance in addition to the District-provided coverage. You may also purchase life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage (up to $100,000 for yourself, and up to $20,000 for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee— In increments of $10,000 up to $500,000

Spouse— In increments of $5,000 up to $250,000 (not to exceed 50% of EE's amount)

Children— Option of $1,000, $5,000, or $10,000

Voluntary Life Rates (Per Pay Period—24/Year)			
Age	Employee per $10,000	Spouse per $10,000	Children per $1,000
< 29	$0.75	$0.21	All Eligible Children: $0.180 per $1,000
30-34	$1.35	$0.28	
35-39	$1.35	$0.36	
40-44	$1.35	$0.52	
45-49	$1.35	$0.80	
50-54	$2.00	$1.40	
55-59	$3.65	$2.58	
60-64	$5.25	$3.86	
65-69	$9.90	$6.26	
70-74	$17.45	$11.62	
75-79	$64.70	$38.52	
80+	$64.70	$38.52	
AD&D	$0.030	$0.015	$0.015

* Employee and Spouse Rates based on employee's age as of July 1.

VALUE-ADDED SERVICES

Administrated By the Hartford

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

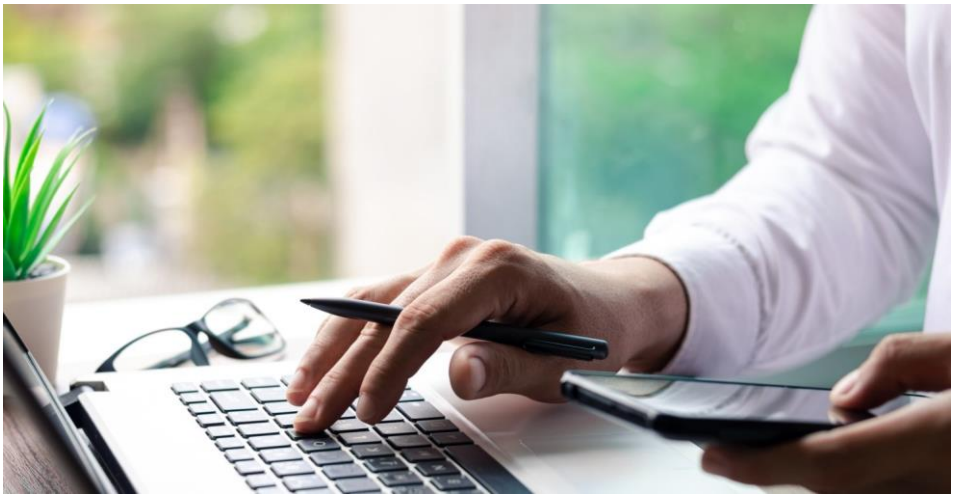
The Employee Assistance Program is available to all employees and any member of your household. The Value-Added Services can help you with the following:

- Emotional or Work--Life Counseling
- Relationship/Marital Conflict
- Financial Counseling
- Legal Counseling
- Health and Benefit Services
- Greif and Loss
- Stress, anxiety and depression
- Estate Guidance
- Funeral Concierge Services
- Travel Assistance
- Identity Theft
- And More!

CONTACT **INFORMATION**

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

Benefit	Administrator	Phone	Website/Email
Medical	HealthPartners	800.883.2177	www.healthpartners.com
VEBA	Mid-America	855.329.0095	www.midamerica.wealthcareportal.com
Dental	Health Partners	800.883.2177	www.healthpartners.com
Flexible Spending Account	Mid-America	855.329.0095	www.midamerica.wealthcareportal.com
Life and AD&D	The Hartford	888.563.1124	www.thehartford.com
Voluntary Life and AD&D	The Hartford	888.563.1124	www.thehartford.com
Critical Illness	The Hartford	866.547.4205	www.thehartford.com
Long Term Disability	The Hartford	888.277.4767	www.thehartford.com
Benefits Manager	District Human Resources	612.706.1006	HR@isd282.org



LEGAL NOTICES

HIPAA Special Enrollment Rights

St Anthony New Brighton School District 282 Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the St Anthony New Brighton School District 282 Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact District Human Resources at 612.706.1006 or HR@isd282.org.

Important Warning

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

LEGAL NOTICES

Notice of Creditable Coverage

Important Notice from St Anthony New Brighton School District 282

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with St Anthony New Brighton School District 282 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **St Anthony New Brighton School District 282 has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current St. Anthony New Brighton School District 282 coverage will not be affected. The $1500 VEBA plan offers the following prescription drug coverage for a 1-month supply: 100% coverage after the deductible has been met for formulary generic and formulary brand drugs. Members may keep this coverage if they elect part D and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at **http://www.cms.hhs.gov/CreditableCoverage/**), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current St. Anthony New Brighton School District 282 coverage, be aware that you and your dependents may be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with St Anthony New Brighton School District 282 and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through St Anthony New Brighton School District 282 changes. You also may request a copy of this notice at any time.

LEGAL NOTICES

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**July 01, 2025**
Name of Entity/Sender:	**St Anthony New Brighton School District 282**
Contact—Position/Office:	**District Human Resources**
Office Address:	**3303 33rd Ave Ne** **St Anthony, Minnesota 55418-1704** **United States**
Phone Number:	**612.706.1006**

LEGAL NOTICES

Women's Health & Cancer Rights Act

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

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

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

$1,500 VEBA Plan (Individual: 0% coinsurance and $1,500 deductible; Family: 0% coinsurance and $3,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 612.706.1006 or HR@isd282.org.

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
St Anthony New Brighton School District 282 is committed to the privacy of your health information. The administrators of the St Anthony New Brighton School District 282 Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting District Human Resources at 612.706.1006 or HR@isd282.org.

LEGAL NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

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

LEGAL NOTICES

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

LEGAL NOTICES

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

LEGAL NOTICES

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

LEGAL NOTICES

COBRA General Notice

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

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

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

LEGAL NOTICES

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

St Anthony New Brighton School District 282
District Human Resources
3303 33rd Ave Ne
St Anthony, Minnesota 55418-1704
United States
612.706.1006

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

LEGAL NOTICES

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact District Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

LEGAL NOTICES

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name St Anthony New Brighton School District 282		4. Employer Identification Number (EIN) 41-6001400
5. Employer address 3303 33rd Ave Ne		6. Employer phone number 612.706.1006
7. City St Anthony	8. State Minnesota	9. ZIP code 55418-1704
10. Who can we contact about employee health coverage at this job? District Human Resources		
11. Phone number (if different from above)	12. Email address HR@isd282.org	

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

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

  ☐ All employees. Eligible employees are:

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☐ We do offer coverage. Eligible dependents are:

  ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

LEGAL **NOTICES**

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

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

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

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

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

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

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

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

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

LEGAL **NOTICES**

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

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

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

Notes

Notes

This benefit summary prepared by

Gallagher

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