St. Anthony New Brighton
INDEPENDENT SCHOOL DISTRICT 282

2023-2024

Employee Benefit Summary

Benefits Overview

St. Anthony New Brighton School District 282 is proud to offer a comprehensive benefits package to eligible employees. We have briefly summarized the benefits available in this booklet. The full plan booklets, which give you more detailed information about each of these programs are available on our benefits portal or can be requested from Human Resources..

You share the costs of some benefits (medical and dental), and based on your contract, St. Anthony New Brighton School District 282 provides other benefits at no cost to you (Life, Long-Term Disability). In addition, there is a voluntary life and AD&D coverage with reasonable group rates that you can purchase through payroll deductions.

Benefit Plans Offered

- Medical
- Flexible Spending Accounts (FSA)
- Dental
- Life Insurance / AD&D
- Voluntary Life and AD&D
- Long-Term Disability

Eligibility

All employees must make an election for themselves and any eligible dependents within 30 days of the date they first become eligible. In addition, an employee must enroll a newly acquired dependent (such as a new spouse) within 30 days of when the new dependent is first acquired. All benefits for newly hired employees will be effective on your date of hire.

Late Enrollment: if you do not enroll yourself or any eligible dependents within 30 days of the date that you or your dependents first become eligible, you may enroll yourself and any eligible dependents during the annual open enrollment period.

There may be additional situations when you are eligible to enroll yourself and any eligible dependents after the first 30 days of eligibility. If you have questions about the items included in this summary, please contact Human Resources.

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

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.

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. This is a fast and convenient way 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 60 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 is available 24/7, 365 days a year and only costs up to $59 per visit. Virtuwell is integrated into the billing process whereby claims are applied to your deductible and out-of-pocket maximum. Save a trip to urgent care and use Virtuwell instead!

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 starting on page 4 of this document.

2023-2024 Medical Rates

Per Pay Period		
$1,500 VEBA		
	Teacher	Non-Teacher
Single	$70.82	$70.82
Family	$213.30	$213.30

*Please Note: Premium rates reflect employees with greater than 70% FTE status. For employees working 50%-70%, please refer to your Cost Sheet. All employees below 50% are not eligible for health and dental insurance.

Medical Plan Summaries

Administered by HealthPartners

	$1,500 VEBA	
	In-Network	Out-of-Network
Lifetime Benefit Maximum	Unlimited	
Annual Deductible	$1,500 Individual / $3,000 Family	$1,750 Individual / $3,500 Family
Annual Out-of-Pocket Maximum (includes deductible)	$1,500 Individual / 3,000 Family	$3,500 Individual / $7,000 Family
Coinsurance	0%	20%
District / VEBA Contribution	$550 Individual / $1,100 Family	
DOCTOR'S OFFICE		
Office Visits	Deductible then 100% coverage	Deductible then you pay 20% coinsurance
Wellness Care (routine exams,immunizations, well baby care)	No charge	Deductible then you pay 20% coinsurance
Diagnostic Test and Imaging (x-ray, blood work, CT/PET scans, MRIs)	Deductible then 100% coverage	Deductible then you pay 20% coinsurance
HOSPITAL SERVICES		
Emergency Room	Deductible then 100% coverage	Deductible then 100% coverage
Hospital Deductible	Deductible then 100% coverage	Deductible then you pay 20% coinsurance
Inpatient	Deductible then 100% coverage	Deductible then you pay
Outpatient Surgery	Deductible then 100% coverage	Deductible then you pay 20% coinsurance
Ambulance Service	Deductible then 100% coverage	Deductible then you pay 20% coinsurance
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Inpatient Services	Deductible then 100% coverage	20% coinsurance
Outpatient Services	Deductible then 100% coverage	20% coinsurance
OTHER SERVICES		
Maternity Services	Deductible then 100% coverage	20% coinsurance
All Other Maternity Hospital / Physician Services	Deductible then 100% coverage	20% coinsurance
Physical, Occupational and Speech Therapy Services	Deductible then 100% coverage	20% coinsurance
PRESCRIPTION DRUGS		
Generic Drug (30-day supply)	Formulary: 0% coinsurance Non-Formulary: Not covered	Formulary: 20% coinsurance Non-Formulary: Not covered
Retail—Formulary Drug (31-day supply)	Deductible then 100% coverage	20% coinsurance
Retail—Non-Formulary Drug (31-day supply)	Not covered	Not covered
Mail Order—Generic Drug (93-day supply)	Formulary: Deductible then 100% coverage Non-Formulary: Not covered	Not covered
Mail Order—Formulary Drug (93-day supply)	Deductible then 100% coverage	Not covered
Mail Order—Non-Formulary Drug (93-day supply)	Not covered	Not covered

This analysis 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 more details. Policy forms for your reference will be made available upon request.

Medical Insurance Terminology

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

Deductible

A deductible is the amount of money you or your dependents must pay toward a health claim before your insurance plan makes any payments for healthcare services rendered. This amount is an annual amount calculated during the plan year, 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 filed on your behalf with HealthPartners (HP). Once HP processes the claim, you will receive an EOB. The EOB tells you the total amount of the claim, what the provider must "write off" based on their provider contract with HP, what HP paid and what you owe on the claim.

The EOB also shows what's accumulated toward your annual OOPM and deductible, if applicable.

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

A tax-free medical expense account funded by the District on your behalf if you enroll in the $1,500 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.

Open Access (OA)

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

High-Deductible Health Plan (HDHP)

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

Summary Plan Description (SPD)

The Summary Plan Description is a summary of the master plan document. You may receive your SPD by contacting HealthPartners' Member Services, your Human Resources team or by logging into **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 (FSAs) – Health and/or Dependent Care Reimbursement

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 $3,050 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 file 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 (Federal State and FICA estimated at 30%)*	-$7,200	-$6,150
Less Premium and Out-of-Pocket Expenses	-$3,500	-$3,500
Plus Reimbursement from FSA	$0	+$3,500
Take-Home Pay	$13,300	$14,350

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

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

Carryover Provision: If you have money leftover at the end of the plan year, up to $610 will carryover. The amount carried forward may be used at any time during the next plan year.

Dental Benefits

Administered by Delta Dental

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 School District 282's dental plan.

Delta Dental of Minnesota 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 Delta is different for participating dentists and nonparticipating dentists. If you see a nonparticipating dentist your out-of-pocket expenses may increase.

Benefit Maximums

The Plan pays up to a maximum of $1,250 for each covered person per calendar year (January 1- December 31) 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.

The plan also provides a lifetime maximum of $1,000 for orthodontia services. This benefit applies to dependent children ages 8-15.

Deductible

There is **no deductible** if you see a **Delta Dental PPO** provider. For all Premier and Nonparticipating providers, there is a $25 deductible per Covered Person each Plan Year not to exceed 3 times that amount ($75) per Family Unit. The deductible does not apply to Diagnostic and Preventive Services.

The following is an overview of your Delta Dental coverage. For exact coverage terms and conditions, consult your plan materials.

Dental Plan through Delta Dental			
	Delta Dental PPO	Delta Dental Premier	Non-Participating
Annual Deductible	None	$25 / person $75 / family	$25 / person $75 / family
Annual Benefit Maximum	$1,250	$1,250	$1,250
Preventive Dental Services (cleanings, exams, x-rays)	100%	100%	100%
Basic Dental Services (fillings, root canal therapy, oral surgery)	100%	80%	80%
Oral Surgery (surgical / nonsurgical extractions, all other covered oral surgery)	80%	80%	80%
Major Restorative (crowns, crown repairs)	50%	50%	50%
Prosthetic Repairs and Adjustments (denture adjustments and repairs, bridge repair)	100%	50%	50%
Prosthetics + (dentures – full and partial, bridges)	50%	50%	50%
Lifetime Ortho Maximum*	$1,020	$1,000	$1,000
Orthodontic Services Dependent children under age 19	50%	50%	50%

*If dental services are received from a non-participating dentist, you will be responsible for paying the difference between the maximum allowable amount and what the dentist charges.

This analysis 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 more details. Policy forms for your reference will be made available upon request.

Dental Benefits (continued)

Administered by Delta Dental

2023-2024 Dental Rates

Per Pay Period		
	Teacher	Non-Teacher
Single	$0.35	$0.00
Family	$2.72	$4.32

*Please Note: Premium rates reflect employees with greater than 70% FTE status. For employees working 50%-70%, please refer to your Cost Sheet. All employees below 50% are not eligible for health and dental insurance.

How do I find a Participating Dentist?

Dental Dental's in-network dentists are called PPO and Premier dentists. PPO dentists are providers that Delta Dental has contracted with to provide you the deepest discounts on services, thereby helping your Annual Maximum to go further. Premier dentists are also in-network, just with different contracted rates than PPO dentists.

To find an in-network dentist nearest you, visit **www.deltadentalmn.org**, click on "Find Dentist," then under Select Your Network choose the "PPO and Premier Networks" option from the drop-down menu. Then, under Pick Your Location, enter your location and search. You may also call Customer Service locally at **651.406.5916** or toll-free at **800.553.9536**.

Life and Accidental Death & Dismemberment Insurance

Insured by The Standard

The District provides Basic Life and Accidental Death & Dismemberment coverage at no cost to you.

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

When you enroll in a Life Insurance policy you need to designate a beneficiary. Since the most current beneficiary form determines who will receive your benefit, it is important to review your designation from time to time. You can change your beneficiary at any time by filling out a new beneficiary form and returning it to Human Resources.

Voluntary Life Insurance

Insured by The Standard

This coverage is offered to employees as a way to supplement the District-paid Life / AD&D coverage. This coverage also provides employees with a way to obtain coverage for their spouse and/or dependent children. Because this coverage is offered on a group basis through the District, the cost is generally less than what an employee would find if seeking coverage on their own. **Note**: You must purchase supplemental Life / AD&D insurance for yourself in order for your dependents to be eligible. Dependent children are eligible to age 19, or 25 if a full-time student and primarily supported by you.

As an eligible employee under this plan, see your rate sheet for available coverage amounts.

If you decline supplemental life coverage for yourself and dependents upon hire and decide you want coverage in the future, you will be required to provide “Proof of Good Health” on all amounts of coverage and coverage may be denied. For more specific information regarding life and LTD, see your certificates of coverage.

Voluntary Life Rates			
Age	Employee	Spouse	Child(ren)
	Monthly Cost per $1,000 of coverage		
24 + Under	$0.150	$0.080	All Eligible Children: $0.180 per $1,000
25–29	$0.240	$0.098	
30–34	$0.240	$0.098	
35–39	$0.240	$0.130	
40–44	$0.240	$0.192	
45–49	$0.240	$0.304	
50–54	$0.370	$0.544	
55–59	$0.700	$1.018	
60–64	$1.020	$1.530	
65–69	$1.950	$2.488	
70–74	$3.460	$4.634	
75–99	$12.910	$15.394	
AD&D	$0.030	$0.030	$0.03

* Employee and Spouse rates based on employee’s age as of July 1.

Long-Term Disability

Insured by The Standard

Meeting your basic living expenses can be a real challenge if you become disabled. Long-Term Disability coverage provides a reasonable replacement of monthly earnings to an individual who becomes disabled for an extended period of time, due to accident or illness. 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 employer 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.

Employee Assistance Program (EAP)

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

If you find yourself wanting to connect with a counselor in-person rather than over the phone, the EAP can help to connect with someone to help. Simply call the EAP number listed below and they will assist in finding and scheduling an appointment with a counselor. The best part is if you go through the EAP, the first 3 sessions per issue, per year, are FREE! Take advantage of these great benefits today!

HealthPartners / Sourcewell – Employee Assistance Program (EAP)

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

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

Take advantage of online resources:

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

TELEPHONE	ONLINE RESOURCES
Contact the EAP toll-free at: 1.866.326.7194 **24 hours / day, 7 days/week**	- Enter www.hpeap.com in your web browser. - Enter sourcewell as the password (in all lowercase letters).

Contact Information

If you have specific questions about any of the benefit plans, please contact the administrator listed below, or your Human Resources department.

Benefit	Administrator	Phone	Website
Medical (5134)	HealthPartners	952.883.5000	www.healthpartners.com
Dental (4009)	Delta Dental	800.328.1188	www.deltadentalmn.org
Life and AD&D Insurance	The Standard	800.628.8600	www.standard.com
Voluntary Life and AD&D Insurance	The Standard	800.628.8600	www.standard.com
Long-Term Disability	The Standard	800.368.1135	www.standard.com
Flexible Spending Accounts	Mid-America	855.329.0095	www.midamerica.wealthcareportal.com
Employee Assistance Program	HealthPartners	866.326.7194	www.hpeap.com Password: sourcewell

Annual Notices

1. Summary of Plan Description (SPD)
2. Summary of Benefit Coverages (SBC)
3. HIPAA Special Enrollment Rights
4. Annual Medicare Part D Certification (creditable or non-creditable coverage notice)
5. Medicaid and the Children's Health Insurance Program Offer Free or Low-Cost Health Coverage to Children and Families (CHIPRA Notice)
6. Women's Health and Cancer Rights Act Annual Notice
7. Newborn's and Mother's Health Protection Act
8. HIPAA Notice of Privacy Practices
9. Initial/General Notice of COBRA Continuation Coverage Rights

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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 Kim Lannier – Human Resources at **612.706.1006** or **klannier@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.

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 Deductible 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 November 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.

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:	7/1/2023
Name of Entity/Sender:	St. Anthony New Brighton School District 282
Contact--Position/Office:	Kim Lannier – Human Resources
Address:	3303 33rd Avenue NE Minneapolis, MN 55418 United States
Phone Number:	612.706.1006

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Women's Health and Cancer Rights Act Annual Notice

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

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

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

$1,500 – 100% 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 Kim Lannier – Human Resources at **612.706.1006** or **klannier@isd282.org**.

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Newborn's and Mother's 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).

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 **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 **866.444.EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.766.9012
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 617.886.8102
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

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

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 20230 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2024)

General Notice of COBRA Continuation Coverage Rights

Upon enrollment in our medical, dental and/or life coverage, we are required to send you (and your family) the **General Notice of COBRA Continuation Coverage Rights**. This notice explains continuation of your coverage and when it may become available to you and/or your family members under the federal COBRA law. It also provides you important information regarding your responsibilities if you were to experience a "qualifying event". For instance, if your dependent child loses eligibility on the St. Anthony New Brighton School District 282 plan, you must notify Human Resources in writing within 60 days. If you fail to notify your employer, your dependent would lose their right to COBRA continuation. This document is important to read so you are aware of St. Anthony New Brighton School District 282 and your rights and responsibilities.

General Notice of COBRA Continuation Coverage Rights Notice of COBRA Continuation Coverage Rights (For St. Anthony New Brighton School District 282 Health Plan)

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: 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.

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, Medicaid, 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**.

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
Kim Lannier – Human Resources
3303 33rd Avenue NE
Minneapolis, Minnesota 55418
United States
612.706.1006

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.

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HIPAA Notice of Privacy Practices

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 Kim Lannier – Human Resources at **612.706.1006** or **klannier@isd282.org**.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-883-2177 or visit us at www.healthpartners.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,500 Individual, $3,000 Family Out-of-network: $1,750 Individual, $3,500 Family Your employer HRA contribution helps cover the cost of the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $1,500 Individual, $3,000 Family Out-of-network: $3,500 Individual, $7,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.healthpartners.com/OpenAccess or call 1-800-883-2177 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance	Office Visit: 20% coinsurance Convenience Care: 20% coinsurance virtuwell: Not covered	None
	Specialist visit	0% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance	See www.sourcewell-mn.gov/health for Omada digital health support programs. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	Formulary: 0% coinsurance Non-formulary: Not covered	Formulary: 20% coinsurance at retail, mail not covered Non-formulary: Not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	0% coinsurance		
	Non-formulary brand drugs	Not covered		
	Specialty drugs	0% coinsurance	20% coinsurance at retail, mail not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html				
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	20% coinsurance	None
	Inpatient services	0% coinsurance	20% coinsurance	None
If you are pregnant	Office visits	No charge	20% coinsurance	None
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	20% coinsurance	None
	Habilitation services	0% coinsurance	20% coinsurance	None
	Skilled nursing care	0% coinsurance	20% coinsurance	120 day maximum
	Durable medical equipment	0% coinsurance	20% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	0% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Long-term care	• Routine foot care
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Hearing aids	• Non-emergency care when traveling outside the U.S.
• Bariatric surgery	• Infertility treatment - See www.sourcewell-mn.gov/health for information about Progyny	• Routine eye care (Adult)
• Chiropractic care		

Your Rights to Continue Coverage There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Your plan at:1-800-883-2177 or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:Your plan at: 1-800-883-2177.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-883-2177.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-883-2177.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,500**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,500**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

Notes

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This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting